The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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Contents

June, 1959, Volume 36, No. 6

Cover Picture—Front row: Past presidents of the Canadian Hospital Association who received pins at 1959 biennial meeting. Back row: Those who presented the pins (see page 52 for names)

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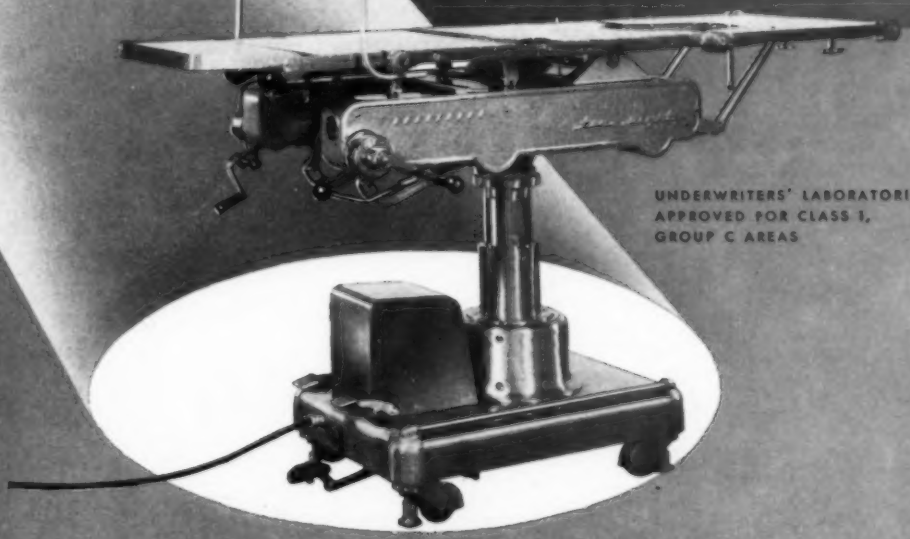

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p. 7-12 adv.

Notes About People

P.E.I. Commission Named

A five-man commission, headed by Dr. L. E. Prowse of Charlottetown, has been named to administer the Prince Edward Island Hospital Services Act. Vice-chairman is T. Earle Hickey, C.A., of Summerside. Other members of the board include Lt. Col. Leo F. MacDonald, trustee of the Charlottetown Hospital; Robert MacLeod, a Charlottetown lawyer; and George Ferguson, a merchant from Murray River. Comptroller for the commission is G. D. Dennis, C.A., of Charlottetown, who until recently was employed by the Income Tax Branch at Hamilton, Ontario.

William Cone, M.D.

Dr. William Cone, who was co-founder with Dr. Wilder Penfield of the Montreal Neurological Institute, and ranked as one of the world's leading brain surgeons, died suddenly on May 5 in Montreal, Que. He was 62.

Dr. Cone came from Iowa and was a graduate of the University of Iowa and of the Columbia University in New York. It was in New York, at the Presbyterian Hospital, that he first met Dr. Penfield. In 1928 Dr. Cone came to Montreal as lecturer in neurosurgery at McGill University, the next year he was made assistant professor and in 1935 was named assistant professor of neurosurgery. Seven years later he also became professor of neuropathology.

He served overseas during the second world war and organized, with Col. Colin K. Tussel, the No. 1 Neurological Hospital where he was chief neurosurgeon.

At Home for Aged

Appointed administrator for the newly opened Kipling Acres Home for the Aged in Etobicoke, Ont., is L. Anthony Quaglia. Mr. Quaglia, who has studied hospital administration at the University of Toronto, was formerly administrator at Hill Top Acres, a home for the aged in Toronto.

New Dean at U. of Alta

Dr. Walter Campbell MacKenzie will succeed Dr. John Scott as dean of medicine at the University of Alberta. Dr. Scott will retire as dean in August after 36 years of service.

Dr. MacKenzie was born in Glace Bay, N.S., and graduated with an M.D., C.M., from Dalhousie University in Halifax in 1933, when he was awarded the medal of the Malcolm Honour Society. For two years he was a Fellow in Surgery at the Mayo Foundation, and following that was Surgical First Assistant at the Mayo Clinic. He graduated as Master of Surgery from the University of Minnesota in 1937.

He first joined the staff of the University of Alberta as an assistant demonstrator in 1939. After naval wartime service, Dr. MacKenzie returned to the university as an instructor, and was promoted successively to lecturer and clinical professor. In 1950 he became professor and head of the department of surgery, posts which he now holds.

Joins C.H.A. Staff

George McCracken, who, for the past year, has been serving an administrative residency at Hamilton General Hospitals, Hamilton, Ont., has been appointed an assistant director of the Canadian Hospital Association. He joins the headquarters staff July 1st.

Born in Glasgow, Scotland, Mr. McCracken came to Canada while very young and, in World War II, he served with the Royal Canadian Navy. He graduated from the University of Toronto, with a bachelor of arts degree, in 1948. For two years after that he was student auditor at the MacDonald Curry Company, Toronto. He was then employed for two years as a senior clerk in the accounting office of General Steel Wares Limited in Toronto. He was also internal auditor with the A. V. Roe Company from 1952 to 1956. Then, for one year, he was comptroller and office manager at the Queensway General Hospital in Metropolitan Toronto.

George McCracken

At this period Mr. McCracken became interested in improving his qualifications for work in the hospital field and enrolled in the 1957-1959 class in hospital administration at the University of Toronto. During his second or residency year, he has been under the preceptorship of Dr. W. E. Noonan and Dr. H. E. Appleyard at Hamilton General Hospitals. We are glad to welcome Mr. McCracken to the national office.—*Edit.*

J. Cecil McDougall

James Cecil McDougall, B.Sc., B.Arch., F.R.A.I.C., F.R.I.B.A., P.Eng., one of Canada's foremost architects, died suddenly in Montreal, Que., on April 20, 1959. He was 72 years of age.

Mr. McDougall, who was born in Three Rivers, Que., graduated from McGill University in architecture and engineering—a combination which has made him a most valuable member of his field. He played an important part in the design and construction of four large Montreal hospitals — the Montreal General, the Montreal Children's, the Jewish General, and the Royal Edward Laurentian, as well as in many other institutions, public, industrial and private buildings. At the time of his death Mr. McDougall was consultant to Fleming and Smith of Montreal, a firm in which he had been senior partner for many years.

From 1942 he represented McGill University on Montreal's city council. He was also a past-president (1926) of the Province of Quebec Association of Architects, a member of the Sir George Etienne Cartier Corporation, and was chairman of the planning committee for construction of Montreal's Place des Arts, a new concert hall.

We would like to express our

(continued on page 24)

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People
(continued from page 14)

deepest sympathy to Mrs. McDougall, president of the National Council of Hospital Auxiliaries of Canada, Inc.

In Calgary at Grace Hospital

Major Marguerita West is now at Grace Hospital, Calgary, Alta., as the new superintendent. She comes to this appointment from Vancouver, B.C., where for the past six years she was assistant superintendent and director of nurses at the Salvation Army Grace Hospital. Major West is a graduate of the Grace Hospital, Windsor, Ont., and has worked on staff there as well as at the Grace Hospital, Toronto, Ont., and the Catherine Booth Hospital in Montreal, Que. In Calgary, she succeeds Major Gertrude Pedlar, who has moved to the Salvation Army Hospital in Sydney, N.S.

Guelph Administrator

W. A. O. Whitworth has been named administrator at the Guelph General Hospital, Guelph, Ont. Mr. Whitworth comes to his new post from the Douglas Memorial Hospital in Fort Erie, Ont., where he had been superintendent since 1954. He succeeds A. T. Story who left Guelph to go to the St. Catharines General Hospital.

Editor for French Edition of "Canadian Nurse"

First French assistant editor for the *Canadian Nurse* is Gabrielle D. Coté. Miss Coté will edit the French version of the publication which comes off the press for the first time this month.

She is a graduate of l'Hôpital Ste-Justine's school of nursing in Montreal, Que., and holds as well a public health nursing certificate, a diploma in administration and supervision in public health nursing, and a bachelor of nursing degree from McGill University. She has a master of arts degree from Columbia University in New York. Except for service with the R.C.A.M.C. during the second world war, Miss Coté has been with the Montreal Department of Health since 1930 as staff nurse, supervisor, and finally as assistant director of nursing services. Bilingual from childhood, she has studied at the Sorbonne in Paris and is at present treasurer of the Association of Nurses of the Province of Quebec.

Thomas R. Wiley

Thomas R. Wiley, Canadian architect, died on May 19 at his home in St. Catharines. He was 52.

Mr. Wiley, a member of the Royal Architectural Institute of Canada, was awarded a Massey Medal last year for his contribution to Canadian architecture, especially for his part in the design of the Workmen's Compensation Board Hospital and Rehabilitation Centre in Downsview, Ont.

At Royal Alexandra

Dr. Kenneth J. Williams, formerly of Grace New Haven Hospital, New Haven, Conn., has been appointed associate medical superintendent at the Royal Alexandra Hospital, Edmonton, Alta., to assist Dr. D. R. Easton in the administration.

Born in Vancouver, B.C., Dr. Williams worked in lumber camps before entering the University of Manitoba from where he gradu-

(concluded on page 30)

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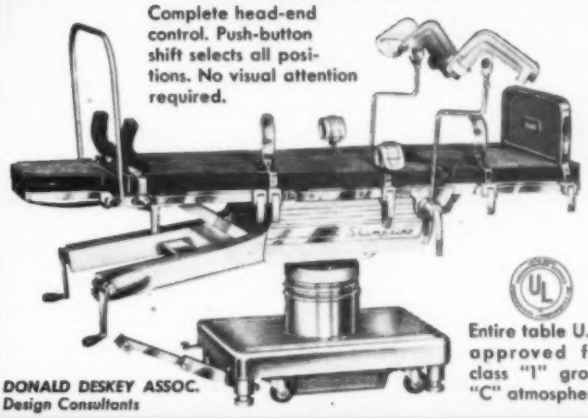

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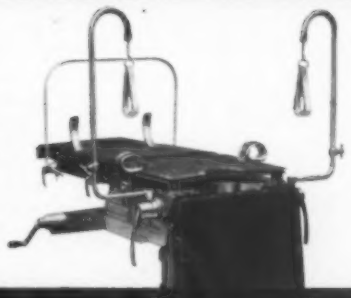

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ated in 1948. In 1957 Dr. Williams enrolled as a post-graduate student in a hospital administration course at Yale University, School of Medicine. He has been at the New Haven Hospital since that time.

T. B. Hurst Honoured

T. B. Hurst, an outstanding personality in the history of radiography in Canada, was honoured recently at a gathering in Toronto. The occasion was the retirement of Mr. Hurst from his post as chief technician at the Toronto General Hospital.

In a brief speech, Dr. A. C. Singleton, chief of radiology at the Toronto General, reviewed Mr. Hurst's career and achievements. He paid special tribute to the work Mr. Hurst had done during his more than 40 years of service with the hospital.

Ida A. Brand

Ida Beatrice Brand, director of the Ontario Branch of outpost hospitals for the Canadian Red Cross Society, died on May 3 in Toronto, Ont.

Miss Brand, born near Brantford, Ont., received her nursing training at the Hamilton General Hospitals, graduating in 1926. She later attended a course in public health at the University of Toronto.

During her work for the outpost hospitals, Miss Brand was at Thessalon, Apsley, Redditt, Lion's Head, New Liskeard and Haliburton, and in 1939 was appointed supervisor of the hospitals throughout Ontario. Later she became director, stationed in Toronto.

J. I. Monteith

J. I. Monteith, who was chairman of the board at Kelowna General Hospital, Kelowna, B.C., died suddenly on March 23. Mr. Monteith had been chairman since 1954, and before that director from 1952. He is succeeded as chairman by R. P. Walrod.

Hospital Honours Physician

A framed, illuminated scroll was presented to Dr. Gordon B. Wiswell at the annual meeting of the Children's Hospital in Halifax, N.S. Dr. Wiswell, who has been associated with the hospital for 36 years, is resigning from the office of physician-in-chief of medical services, a post which he has held for the past ten years.

- Dr. J. R. Boutin, medical director of L'Hôpital Notre-Dame, Montreal, Que., has been elected president of the Montreal Hospital Council, succeeding Dr. J. Gilbert Turner in this post.
- Sr. Rita Fortier became Sister Superior and administrator of the Regina Grey Nun's Hospital, Regina, Sask., on March 20, 1959. She succeeds Sr. Marie Jeanne Tougas.
- J. Albert Blais, assistant director of family allowances since 1946, has been appointed national director of the Family Allowances and Old Age Security Division of the Department of National Health and Welfare.
- Mrs. E. C. Reid, a graduate of the Galt School of Nursing, Lethbridge, has been named as director of nursing at the Galt Rehabilitation Centre in Lethbridge, Alta. She succeeds Audrey McKenzie in this post.

It is in trifles, and when he is off his guard, that a man best shows his character. — *Arthur Schopenhauer.*

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

C.H.A.'s 15th biennial

DURING May 11-13 the Canadian Hospital Association held its 15th biennial meeting at the Queen Elizabeth Hotel, Montreal. The constitution of the association limits the voting to 37 delegates from hospital associations, Catholic hospital conferences and the Canadian Medical Association, but a large number of alternates and visitors were in evidence. Although a good portion of the three-day meeting was devoted to the transaction of business relating to the association, time was found also for the discussion of several topics of current interest to hospital people throughout Canada.

The meeting was noteworthy in several ways. It was the first time that the assembly used simultaneous translation, and this innovation speeded up proceedings. It is probably the last time that the association will meet on a biennial basis, as the assembly decided henceforth to meet annually. Actually the assembly at Saskatoon in 1957 requested the board of directors to give the matter of annual meetings serious consideration; and as a result the assembly met in Toronto in May 1958 for a two-day business session. The meeting just concluded in Montreal followed the usual pattern. The time, place and type of meeting for 1960 has been left for the incoming board to decide.

The 15th biennial meeting may be remembered as the last of its type and it will certainly be recalled for the unique opportunity afforded to honour the past presidents of the association. In the fall of 1957 the board of directors decided to establish a past president's pin. All five past presidents were guests of the association at the dinner on May 12 and received their pins in recognition of their services to the association in a simple yet impressive ceremony. The president, Dr. Porter, had a happy thought when he decided to have the pins presented individually. Each was presented by someone who had a long experience with the affairs of the association, or who represented an organization which had supported the association over the years. The organizations represented were the Sun Life Assurance Company of Canada which has given generous financial support to the secretarial work of the association since its inception, and the Canadian Council of Blue Cross Plans which has given a financial grant to the association for many years. Two people, whose names are closely linked with the Canadian Hospital Association over most of its history—Drs. Harvey Agnew and Lorne Gilday—also participated in the ceremony. From now on as each president retires from office he will be presented with a past-president's pin. Dr. D. F. W. Porter received his from the hand of the incoming president, S. W. Martin, at the closing session on Wednesday afternoon.

Among the several items of business transacted were decisions to proceed with a building program to house the association's office at Imperial Street, Toronto; to expand the educational activities by holding more institutes for various categories of hospital personnel; and to sponsor with the C.N.A. a course in management techniques for head nurses. It was also decided to adopt consolidated billing to member associations whereby, commencing January 1, 1960, accreditation fees will be placed on a bed basis of 17 cents a bed. The revision of the *Canadian Hospital Accounting Manual* will be completed by the fall of 1959. The board of directors were asked to review the constitution and by-laws as they related specifically to representation by member associations and voting procedures for the election of officers and directors. Any recommendations from the board will be transmitted to member associations in ample time for study by the active members before the next meeting of the assembly. For the story of the meeting see page 46 and for the resolutions adopted see page 53.

In the opinion of your editor the 15th biennial meeting marks an important milestone in the development of your national association. In the years to come it may well be referred to as one of the most important in its history.

Progress Report on

Canada's hospital insurance program

An address given by the Hon. J. Waldo Monteith, Minister of National Health and Welfare, at the 15th biennial meeting of the Canadian Hospital Association

IN OPENING, I wish to comment on the excellent co-operation existing between the Canadian Hospital Association and my department. This co-operation is logical in view of our many mutual interests, but it does not happen automatically. It involves a good deal of effort, understanding and patience on both sides. I am, of course, a relative newcomer, but I understand that this collaboration dates back many years and has covered such important fields as research and statistics, the health grants program, and hospital disaster planning. I am told, too, that it has been greatly accentuated with the development of the new hospital insurance plan.

Naturally, I am not in a position to comment on the past. I do know that I have been impressed by the way our two groups have worked together since I took office. Indeed, I have been involved in it myself. I have met with representatives of the Canadian Hospital Association on several occasions, and while I have not always been able to satisfy them, their suggestions have been stimulating and constructive. Mention might also be made of the Technical Conferences on Hospital Insurance which have been sponsored by my department and to which your organization has sent delegates. Finally, there is this meeting itself. Not only have you invited me to open your proceedings, but you have also given over a whole morning to my officials. How much closer a relationship can there be?

There is one other point I would like to make at this stage. Someone has said that every idea has a set time for fulfilment. Whether or not you agree with this, it seems obvious that certain conditions must prevail before any project can be successfully initiated. Put it this way—the ground needs to be carefully prepared in advance. In the case of a legislative program, not only must public opinion require it, but the whole thing must be feasible in practical terms. The matter of hospital insurance in Canada is no exception. The new, federal-provincial program certainly could not have been brought into being without much prior spadework.

And here, I believe, the Canadian Hospital Association deserves much credit, particularly with respect to hospital accounting, and standards of care. On the first point, it is clear that when public funds are paid for a service, the public is entitled to an accurate report on how they are used. More than that, it is entitled to an assurance that tax monies are being used for the purpose for which they are allocated. I do not think it is any exaggeration to say that this might well have been impossible had it not been for the pioneer work of this organization. Through its publication of the *Canadian Hospital Accounting Manual* and related activities, it has helped raise the whole level of hospital accounting in Canada. Recently, the association has done its utmost to bring its recommended procedures into line with the type of financial statement required by federal and provincial legislation. The over-all effect has been to strengthen one of the basic links in the insurance plan's structure.

Financial soundness is important. But it is not the paramount aspect of the hospital insurance program. The most vital thing is the quality of health services which it provides. Here again, the Canadian Hospital Association has made an outstanding contribution. In supporting the Joint Commission on Hospital Accreditation it has thrown its full weight behind a continuing improvement of services in hospital.

As you know the accreditation program has now reached the point where it can be carried forward on an all-Canadian basis. In January of this year, I had the pleasure of helping launch the Canadian Council on Hospital Accreditation, and in so doing, stressed the same point I am making today. I said then: "It is obvious to me that what has already been done in this field has eased the introduction of hospital insurance; that had it not been for this voluntary effort, the plan would face much greater problems in achieving efficiency of operation."

Progress Report

Perhaps the first point we should bear in mind is that the plan is still in its infancy. It has been operating for just ten months in five provinces, and for less than half that time in two others. Obviously, we have not had enough experience to draw sweeping conclusions on how it is working out. Still, there are certain

The Minister is honorary president of the Canadian Hospital Association.

indications as to the general trend of events. On the basis of these, it would appear that things are going extremely well—in fact, better in some respects than might have been expected. Problems have arisen, but the over-all picture is one of smooth and orderly development. Indeed, I think it is fair to say that the federal-provincial program has come through its immediate post-natal period with flying colours.

One of the interesting aspects of this process is the emerging pattern of provincial plans. You may recall that a basic feature of the federal legislation is that there should not be a single national scheme. In view of our constitutional set-up and historic tradition, there should be a series of schemes developed and administered by the provinces and assisted financially and technically by the Dominion government. Their broad outlines must conform to general principles laid down by the federal Act, but their details are to be geared to local conditions and practices. This is exactly what has happened.

Perhaps I might take a few moments to pin-point some of the differences of approach which have developed at the provincial level. I realize that each of you will be familiar with the details of your own provincial program, but you may find it useful to see what is being done in others.

Take, for example, the matter of administration which, as I have said, is left solely to the provinces. Here, we note a considerable variation in the designation of authority:

In Newfoundland and Saskatchewan, responsibility rests with the Deputy Minister of Health.

British Columbia has assigned one of three health deputies as Deputy Minister of Hospital Insurance.

Alberta's program is directed by an officer of its health department other than the Deputy Minister.

In Manitoba, a special commissioner is in charge of operations, with technical advisory services being provided through the Deputy Minister of Health.

Ontario and Nova Scotia have created separate hospital insurance commissions to handle their programs.

In every case, of course, these authorities report to their respective legislatures through their ministers of health.

The plans differ, too, in methods of financing. Under the federal Act, each program receives substantial support from the Dominion government. This is paid out of the "consolidated revenue fund" and amounts to roughly 50 per cent of costs. The remainder is a provincial responsibility. With this responsibility, naturally, goes freedom in choosing how the money should be raised. Here again, there is a diversity of approach, involving such varied techniques as premiums, sales taxes, property taxes, general revenues, or some combination of these. To be specific:

- Saskatchewan, Manitoba and Ontario impose a premium.
- British Columbia draws on general revenues derived in part from a sales tax.
- Alberta levies a property tax.
- Nova Scotia has a special hospital tax.
- Newfoundland relies solely on general revenues.

I might add that British Columbia and Alberta also impose authorized charges, which are charges made directly to patients for insured services. This, you will recall, is permitted by the federal legislation.

A third field of variation is that of eligibility for benefits. All provinces must provide insured services to their residents on uniform terms and conditions. Also, there can be no waiting period for the establishment of resident status. But there can be a waiting period for entitlement to benefits. To illustrate:

- British Columbia, Saskatchewan, Ontario and Nova Scotia require three months prior residence for benefits.
- Manitoba requires one month.
- Alberta and Newfoundland require none.

Clearly, these differences could raise problems for insured persons moving, say, from Alberta to Saskatchewan. There could well be a gap in their coverage. This, however, has been avoided to a large extent. An amendment to the federal Act allows provinces, where necessary, to maintain coverage up to a maximum of three months for people taking up residence in another participating province. In addition to differences in waiting periods, there are also variations in out-of-province benefits. Because of the nature of these two problems, the provinces have asked that a committee be set up under federal auspices to deal with them on a continuing basis.

The final area of diversity I want to mention is the scope of services provided by provincial programs. All plans are uniform in furnishing a basic core of in-patient services. These are laid down in the federal Act and are mandatory for any program in which the Dominion government participates. The Act, however, leaves the matter of out-patient services entirely to provincial discretion. We agree to share the cost of a wide range of these services; but the provinces are free to decide whether they will go into this field at all and, if so, when and how far. For the most part, I think it can be said that provincial governments have been rather cautious in their initial approach to this aspect of hospital care:

Saskatchewan, Manitoba, Ontario and Nova Scotia provide *emergency* out-patient services within a specified period of an accident.

British Columbia does the same, but at its request, these services are not included in the insurance program.

Saskatchewan, Manitoba and Nova Scotia also provide other out-patient services, as does Newfoundland.

Alberta, too, has an out-patient program but it is restricted to recipients of welfare assistance; and so is outside the insurance program which applies only to benefits that are universally available.

Federal Experience

Because there are not yet enough solid facts on which to base far-reaching conclusions, I feel I must be cautious in my remarks. This applies particularly to the matter of utilizing hospital facilities. From time to time in the last few months, reports have appeared in the press indicating the existence of difficult conditions in this or that community across the country. And there have been others indicating the reverse. These are interesting but, being fragmentary and localized, they do not provide a comprehensive idea of the situation.

More reliable are the observations of provincial authorities. In this connection, I was encouraged to note that at the recent Technical Conference no hint was given that provinces are facing unexpected difficulties. Still, the fact remains that we will not have complete information on utilization until the data from annual reports has been analyzed and interpreted.

Quite apart from what the current situation may be, I believe we must recognize that the in-

(continued on page 86)

When Doctors have to find out, just how our bodies run,
Someone pricks our finger, quick-as-wink they get it done
The tiny spot of blood they see helps Doctors quickly tell
Just what it is we need right then to get us running well.

What's the Difference ?

G. A. W. Currie, M.D.
and
F. W. Hunnisett,
Toronto, Ont.

THE 1959 edition of the *Canadian Hospital Directory* lists 1,408 hospitals of all types. Of these only 12 might be classified as strictly children's hospitals — *i.e.*, only children up to 14 or 15 years of age are admitted. (See Fig. I) Most hospitals for adults do have paediatric wards, but here we are concerned with hospitals designed for and admitting children only. It should be noted that the ultra-modern new Hôpital Ste-Justine in Montreal has an obstetrical department, but the preponderance of its 860 beds are paediatric, and therefore it is included in the country's 12 hospitals for children. Although these 12 hospitals represent less than one per cent of the total number of hospitals in Canada, and slightly more than one per cent of the total beds set up, they are making a significant contribution to the health of the nation by "catching them young"!

These 12 hospitals are strategically located—in the cities of Halifax, Montreal, Toronto, Winnipeg, Calgary, Vancouver and Victoria. A crippled children's hospital (with motel accommodation for visiting parents) is on the planning boards of the Ontario Society for Crippled Children in Toronto. The Hamilton Health Association has plans to convert the Wilcox Building of the Mountain Sanatorium to a 230-bed general hospital with 80 designated especially for children.

It is generally conceded that the two largest children's hospitals in the world are in Canada—Ste-Justine in Montreal and The Hospital for Sick Children in Toronto.

Children's hospitals offer highly specialized treatment by physicians, surgeons, radiologists, psychiatrists, nurses and other professional personnel qualified and experienced in children's work. These services are available to every sick child in Canada, thanks to the development of air travel and the improvement of highways, and train and bus service. For example, during 1957 nearly 30 per cent of the patients admitted to The Hospital for Sick Children in Toronto, were from outside Metropolitan Toronto. Children came from every province in Canada, from six states in the U.S.A., and from five foreign countries, *viz.* British West Indies, Colombia, Northern Ireland, Puerto Rica and Venezuela.

Just what is the difference between adult and children's hospitals? Where do the differences lie? Rather than range far and wide we shall try to answer these questions by concentrating and pointing out differences in eight main categories — admissions and public relations, professional staff, therapy and entertainment, dietetics, laundry, patient accommodation, poison control centre, and community support.

In children's hospitals admissions and public relations are

Figure 1

Children's Hospitals in Canada—1959

Hospital	No. of beds
Hôpital Ste-Justine, Montreal	860
The Hospital for Sick Children, Toronto	609
Montreal Children's Hospital, Montreal	339
Children's Hospital, Winnipeg	232
The Children's Hospital, Halifax	175
Alberta Crippled Children's Hospital, Calgary	120
Vancouver Children's Hospital, Vancouver	92
Queen Alexandra Solarium for Crippled Children, Victoria	64
Shriners' Hospital for Crippled Children, Montreal	60
Shriners' Hospital for Crippled Children, Winnipeg	50
Princess Margaret Children's Village, Tbc., Vancouver	64
Home for Incurable Children, Toronto	42

Dr. Currie is superintendent and Mr. Hunnisett is administrative assistant at The Hospital for Sick Children, Toronto, Ontario.

closely related. Of course all the patients are children—a fact which makes a difference even before admission. In hospitals for adults, unless the patient is unconscious or otherwise incapacitated, the patient himself makes his own arrangements for admission, and signs for himself the consent for treatment form. This, of course, is not so in a children's hospital. These arrangements are made for the patient by the parent or guardian.

Parents of sick children who are in hospital are harrassed, worried and upset. Often they have a feeling of guilt and face with sorrow and fear what may be the first separation from their children. An upset parent may have a very disturbing effect on the child, so many children's hospitals have developed admission booklets designed to condition the parent even more than the child. (They are useful for grandparents, too!) All patients in children's hospitals, whether a few hours old (transferred as newborns from an adult's hospital because of some abnormality) or of the maximum age for admittance, represent a problem in communication. The child's reaction to the hospital cannot be directly measured. The parent or guardian must interpret the hospital to the child.

A useful device in conditioning the child to the hospital is the specially designed colouring book which is available in a number of hospitals. The women's auxiliary of The Hospital for Sick Children in Toronto has recently developed and offered for sale in its "555 Shop" just such a book, entitled *Billy Goes to Hospital.** This book attempts to condition the child to the hospital both before and after admission. It suggests things the parents might tell Billy before he goes into hospital. The child takes the book with him and continues to colour it during his hospital stay. The concluding page has space for the child to list the doctors and nurses who attended him as well as his newly-made friends. Significantly, the suggestions for parents include the following: "Remember most children adjust well to hospital, particularly if they have been adequately prepared by you, their parents". Surely this is a more useful book than some of the lurid literature supplied to adult patients by well-meaning but ill-advised friends!

Here's Billy in the playroom, where he has lots of fun.
He's drawing on the blackboard some trees, a man, the sun.
The boys and girls he plays with are doing different things,
And Billy feels so happy he stops a while and sings.

Visiting hours in children's hospitals vary from almost no visiting at all to almost unlimited visiting, but it is safe to say that recently there has been a general relaxation of visiting hour rules. A different set of circumstances surrounds the hospitalization of a child from that surrounding an adult. It is generally harder on the parents and grandparents than on the child, and often the child simply hates to *leave* the hospital. Something taken from home, probably a favourite toy, helps the child adjust to his new environment. Parents are asked to visit the child's room after admission. A number of hospitals encourage parents to assist in entertaining and feeding the child. Some children's hospitals have provisions for mothers to live in the hospital with their children. In at least one hospital in the U.S.A. there is a trained "Hospital Father and Mother", whose duty is to create

Billy in a wheel chair, taking Dobby for a ride
Went down the shiny corridor with Mother by his side.
A Nurse that smiled and waited, showed the way for them to go—
Everyone was friendly, just like people that you know.

**Illustrations shown are reproduced from this book with the kind permission of the women's auxiliary.*

a home-like atmosphere in the hospital.

As an added assistance to parents of out-of-town children, The Hospital for Sick Children, Toronto, has a "Parents' Personal Service", which is under the direction of a kindly registered nurse. This service provides information and help to parents by letter, telephone and wire. This service also assists in obtaining accommodation and transportation.

One of the questions asked the parent at the time of admission is "Has the child been baptized?", particularly if the child is not expected to recover. Many infant baptisms are performed in children's hospitals by clergy of various faiths. Recently in one large children's hospital, in an emergency and in the absence of a clergyman, a nurse baptized a child not expected to recover "Mary Ann", only to discover subsequently that the child was a boy! Happily the child recovered and so did the nurse!

The causes of admission to a children's hospital differ from adult admissions and, of course, they have changed over the years. Figure 2 shows the causes of admission to The Hospital for Sick Children, Toronto, during 1957 out of a total of 22,831 admissions.

A significant comparison of poliomyelitis admissions indicates that in the epidemic years of 1937 and 1953 there were 678 and 348 admissions respectively. Following the widespread administration of Salk vaccine, admissions dropped to 20 in 1956 and 30 in 1957 for poliomyelitis.

The comparatively high number of tonsillectomies and adenoidectomies accounts for a higher percentage of admissions for surgery in children's hospitals.

Still referring to The Hospital for Sick Children, here are some interesting comparisons and changes. Tonsillitis and adenoids does not appear as an admitting diagnosis until 1910, and in that year it was fifth in the leading causes of admission. By 1920 it had gained first place and has been there ever since. In 1910 typhoid fever was the leading cause of admission—with 83 cases. Currently there are only two or three cases each year. Bronchopneumonia has appeared among the six leading causes of admission for the past 50 years, with an average of about third.

The main services are represented with the exception of obstetrics and gynaecology, and geriatrics. However, obstetricians and gynaecologists may be on the consulting staff. The trend in many children's hospitals is for the medical and surgical staffs to be trained in a specialty within a specialty. For example, a surgeon certified in one branch of surgery will tend to confine his work more and more to children's surgery in that specialty. Many paediatricians also specialize within their specialty of paediatrics.

Compared with adults' hospitals relatively large numbers of nurses are required for children's hospitals. For example, the Annual Statistical Report on Public and Private Hospitals in Ontario for the year 1956 indicates that a daily average of 5.08 hours of nursing care were given to each patient in Grade A hospitals. The average in The Hospital for Sick Children was 6.08 hours. Between 40 to 50 per cent of the patients in children's hospitals normally are under two years of age. It is obvious, then, that children require more attention as patients; they need too more care and generally more things done for them than do adults.

Occupational and physiotherapy are as important services in children's hospitals as they are in adult hospitals. The services of physiotherapy departments are being used less and less because of the decrease in the incidence of poliomyelitis. In addition to occupational and physiotherapy, play therapy is provided for children's hospitals. Trained play therapists have a significant part in the treatment of children.

The Toronto Board of Education provides a teacher who gives individual bed-side instruction up to grade 8 to children who have been in hospital for more than one week. Sunday School groups, both denominational and non-denominational are formed for children who can be moved to a common meeting room. The Anglican Diocese of Toronto provides a registered "Church Nurse" who deals with the problems of children and arranges for baptism, confirmation and visiting by the hospital chaplain.

The Toronto Public Library provides a lending library service for children in hospital.

Many organized groups and individuals entertain children throughout the hospitals. Visiting celebrities of stage, screen, circus

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Figure 2

Causes of Admission, 1957

Chronic tonsillitis and adenoiditis	4,776 cases
Bronchopneumonia	586 "
Laryngeal Tracheitis	572 "
Esotropia	564 "
Gastroenteritis due to unknown cause	435 "
Haemolytic disease of the newborn	392 "
Other interesting causes of admission are:	
Hernia	381 cases
Concussion of the brain	342 "
Convulsive Disorder due to unknown cause	252 "
Asthma	187 "
Acute appendicitis	173 "
Poisoning	163 "
Closed fracture of the skull	128 "
Mental deficiency—idiopathic	122 "
Prematurity	63 "
Caries of the teeth	61 "
Poliomyelitis	30 "

Figure 3

Poison Control Centre Treatments

Number of patients treated at the hospital	856
Admission to hospital due to poison ingestion	139 (16 per cent)

Causes	No. of Cases
Internal medicines	515
External medicines	54
Cleaning and polishing agents	118
Pesticides, rodenticides, insecticides	52
Petroleum distillates and turpentine	47
Cosmetics	17
Miscellaneous and unknown substances	53
Total	856

Your President Reports

to the 15th biennial meeting of the Canadian Hospital Association

D. F. W. Porter, M.D.,
Vallée Lourdes, N.B.

IT IS almost two years since the 14th biennial meeting of our association was held at Saskatoon —in conjunction with the Western Canada Institute. Those of us who attended remember quite vividly the success of that meeting and the warm hospitality extended to us. Much of the success was due to the excellent liaison which was maintained between the executive of the Saskatchewan Hospital Association, our host; and the executive staff at C.H.A. headquarters.

You will recall that at the biennial meeting in Saskatoon the delegates asked the board of directors to consider holding annual meetings of our association. As a result we had the assembly meeting in Toronto on May 8th and 9th last year. This was a new departure and consisted of a two-day meeting devoted entirely to business of our association. This time we have reverted to our usual pattern for our biennial meetings.

When Dr. W. D. Piercey and I were in Montreal in March of this year, attending the first convention of the Quebec Hospital Association, we were both much impressed with the facilities which the program committee had provided for simultaneous translation of the speeches and proceedings of that meeting. Through the Junior Chamber of Commerce of Montreal we have been successful in making similar arrangements for our meeting. All speakers, whether speaking from the platform or the floor, may therefore speak in either English or French and their words will be simultaneously translated into the other language. In a bilingual assembly such as ours, we believe that these translation arrangements will speed up our deliberations greatly and will thus render it unnecessary to have summaries of speakers' remarks made in French and English as has been our custom heretofore. In order to make the system work, however, it is necessary for all speakers, whether on the platform or on the floor, to use the microphones provided.

Much has transpired in the hospital field since we met in Saskatoon in 1957. Indeed, much has taken place since we met in Toronto a year ago. There has been the inauguration of the national hospital insurance program; the incorporation of the Canadian Council on Hospital Accreditation; the decision of the assembly in 1958 to construct a headquarters building for the association; the expanding activity of our secretarial staff, including co-operation with active members in promoting institutes and other educational programs.

There is no hospital topic of wider interest throughout Canada today than hospital insurance. Our discussions will be led by representatives of the Department of National Health and Welfare, and I know that you all will gain a deeper insight into the aims and objectives of this program as a result of their participation. We believe that you will have questions to ask, and time has been provided for this. Later we shall turn our attention to a very important facet of hospital work, that of nursing. Leaders in the nursing field will lead the discussion and again an opportunity will be provided for discussion from the floor.

About a year ago your board of directors decided that the past-presidents' services to this association should be recognized. A past-president's pin has been designed and will be presented to these gentlemen at the banquet. Henceforth, as each president retires from office he will be presented with the pin. Also during the banquet one who is no stranger to you will be awarded the George Findlay Stephens Memorial Award for 1959. He is Dr. Angus McGugan of Edmonton.

Hospitals are more and more negotiating with their provincial governments, and you expect your national association to speak on your behalf at the federal level. For these reasons I have been making a study, these past two years, of how the Washington Bureau of the American Hospital Association operates. In February of this year I had the opportunity to spend some hours at this Bureau. In spite of the absence of the director, Kenneth Williamson, my visit proved to be most informative, and his two legal counsels were liberal with their information. Their courtesy to me was quite in keeping with that extended to so many of us over the years by the A.H.A. officers and

staff. We have invited Mr. Williamson to tell us about the program of the Washington Bureau during this meeting. Although the governments of Canada and the United States operate differently, we believe that you will be interested in hearing first-hand how our great sister organization in the United States handles its relationship with the federal government, and perhaps we can learn some lessons.

Permit me to repeat a few things I said at the assembly last year. As there is much going on in the hospital field throughout Canada today, this meeting should give delegates an opportunity of learning first hand what is happening in other parts of the country. We regard this meeting primarily as a clearing house for information, particularly during discussion of association business. You are reminded that this assembly alone has the authority and responsibility of formulating the policies of our national association. It is your duty as delegates to demand that your board of directors inform you fully on how your policies have been carried out. It is also your duty to present your personal views and those of your association or conference to the assembly on all matters pertaining to our collective welfare and future. In brief, this is a family meeting—a meeting of the great family of Canadian hospitals. As members of a family, we have our own private lives, responsibilities and preferences. Let us present our thoughts in frankness and fairness, but we must not let personal aspirations or regional power dominate any of the meetings of this assembly.

Delegates who attended the assembly meeting last year will remember that among the resolutions passed was one instructing our board of directors to press relentlessly and to request urgently favourable consideration of the government of Canada:

(a) that the capital costs problems of hospitals be publicly recognized; that capital costs be officially recognized as an integral part of the total cost of hospital care, and that any calculation of hospital costs from which capital costs are excluded be consistently referred to as partial costs only, and that provision be made for the inclusion of all capital costs as a sharable item in the provision of the Hospital Insurance and Diagnostic Services Act;

(b) that the necessary development of accounting and statistical reporting schedules be carried out by close liaison and consultation among the Dominion Bureau of Statistics, the Department of National Health and Welfare, the governments of the provinces, and the Canadian Hospital Association in view of the mutually advantageous results that this co-operative effort has brought in the past; and

(c) that the operation of the hospital construction grants be made the subject of frequent study and consideration in collaboration with representatives of the association, in the hope that the program may be amended to meet more nearly the objectives recommended by the association.

In attempting to meet this directive from the assembly a delegation met the Prime Minister of Canada, the Hon. John Diefenbaker, and the Minister of National Health and Welfare, the Hon. J. Waldo Monteith, on June 6th, 1958. At that time we presented a brief, which stated that your national association believed most sincerely that depreciation and interest on capital debt should be a shareable cost included in the federal legislation between the government of Canada and the governments of participating provinces. In addition, evidence that the financial security of some hospitals was in immediate and grave danger, as had been predicted by us the previous year, was submitted. Again on January 27th, 1959, a delegation met with the Minister of National Health and Welfare on the same topic. We had a very pleasant meeting and we certainly came away knowing where we stood. For the first time since the present government came into power, we were informed about government policy on this point. The minister told us quite plainly that for the present session of parliament at least, there would be no changes made in the legislation on Bill 320.

Your board of directors realize that in some provinces the question of depreciation on buildings and interest on capital debt is provided for through provincial plans. On the other hand, we are well aware that in other provinces this is not the case. Our contention has been that a national plan such as this will eventually encompass all Canadians and that there should be as much uniformity as possible. Our main contention in discussions with the Prime Minister and the Minister of National Health and Welfare is that to gain this uniformity these items should be a shareable cost between the federal government and participating provinces. Those of your association who have represented you on these delegations believe that in some areas of Canada the very future of our voluntary hospital system is at stake in this question. I do not believe that we have been able to convince our good friends in Ottawa that this is so. It is true that the national plan only became operative July 1, 1958, and therefore a year has not elapsed. For this reason perhaps a clear picture cannot be gained of the financial future of many of our institutions. We can say in all honesty, however, that we know of several institutions in more than one province who at the moment have not found a long-range answer to their financial difficulties, particularly on this question of repayment of existing capital debt.

Other topics that I would like to develop if time permitted are: the need for continuing active leadership of our hospitals at the local level; the need for an increased voluntary effort; the need for a greater effort in promoting in-service education; statistical studies on hospital personnel and the need for a much intensified public relations program at local, provincial and national hospital levels. However, permit me to turn to a topic that is very close to my own heart — the need for unity among hospital groups. If we are to make any impact on the federal and provincial governments, it is up to us to show we are united. For this reason we deplore that some of our hospitals are not members of their provincial or regional associations. We believe the day has long passed when any hospital can live adequately unto itself. Only through the co-operation of all sizes and types of hospitals can we reach a maturity of mind in hospital work which is so necessary to true progress.

During last year alone, I spent over six weeks travelling in Canada and the U.S.A. on visits and missions which I felt were the responsibilities of your president. The main purpose of these visits and those of the previous year was most genuine and sincere; namely to assist in establishing a greater understanding and unity among

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Double Harness

R. W. I. Urquhart, M.D.,

Toronto, Ont.

I SUPPOSE not too many people in this day of long, low, luxurious sedans, or short, snappy, sport coupés have had much experience with the term I have chosen as a title. Truth to tell, I have not had much either, but I am old enough to remember when a smart set of double harness was something to be looked at with pleasure, particularly when fitted to a fine pair of well matched mares or geldings.

Such an outfit was owned by the local doctor in the little village on the prairie where as a small boy I lived for a time. It was my good fortune on vacation to be allowed to accompany the doctor on his rounds as he visited the sick on the neighbouring homesteads. In those days, there were no real roads; but the prairie trails were smooth and the buggy seemed to fly along at a terrific pace behind the doctor's spirited team. In the winter the buggy was replaced by a sleigh or "cutter", as it was called. It was well padded with buffalo robes and the box was filled with straw. In really cold weather a hot stone was placed at the feet.

In those days a round trip of 30 to 50 miles was not uncommon, with little habitation along the way. A good outfit was essential —it could mean the difference between life and death. For this reason the doctor picked his rig with care. It had to be light but rugged enough to take a lot of punishment. The horses had to be fast, well matched and trained to pull well together. They had to work well in double harness.

This term, to work well in double harness, became a common expression to indicate the ability of two people to get on together. For example, the young man about to be married was said to be about to put on double harness and, if after marriage, difficulties developed, or if he strayed from the straight and narrow, it was said that he did not take well to double harness.

Today the expression is pretty well outmoded; but I wonder if it does not have some meaning in the situation in which we now find ourselves. Have you not, as hospital people, been brought together to work with government agencies in double harness, to provide the necessary care for the sick and injured across this great Dominion of ours? I think that you have.

Indeed, if I may be allowed to carry this simile one step further, I would suggest that two other groups, namely, the doctors and their patients, are involved in this business of working in double harness. These groups must pull evenly together with with the hospitals and the government agencies if the provincial hospital plans are to succeed in providing the kind of care we would all want. Let us examine what pulling in double harness means in these situations.

I suppose that the first team which one should look at is the federal-provincial team. This team might be regarded as being hooked up in tandem, for in my view the Department of National Health and Welfare is definitely leading the way and the provincial commissions are following as best they can. I put it this way because I feel that the federal proposals are aimed at stimulating the provinces to develop through the Hospital Insurance and Diagnostic Services program the best possible facilities for the care of the sick. I distinctly get the impression that Ottawa looks with favour—occasionally fortified with funds—on provincial projects to improve the availability of services and the quality of care.

Dr. R. W. Ian Urquhart

Having paid my tribute to the federal authority, however, I would be a poor proponent of the provincial Commission which I represent did I not point out that on some issues the positions in the team seem to have been reversed. The province has taken the lead and has been straining the harness almost to the breaking point to pull a balking, resisting federal authority in the direction in which we felt it should go. To be serious, however, I think I can say sincerely and honestly that Ontario has had the very best of co-operation from the federal authority and that many of the issues on which we are divided can be resolved only through the passage of time. Sooner or later, one or the other of us will change our minds. In my view the federal-provincial team is pulling well in double harness. I am happy to be part of the team.

Wheel Team

The second team which should be examined is the wheel team—the one that is really pulling the load, the provincial Commissions and the hospitals. This is where pulling well and evenly in double harness really counts. The success of the whole plan depends on it. I remember a team of horses which illustrates my point very well. They were not well matched. One horse was a big bony roan who always kept the traces taut and would pull the wagon out from under you if given a chance (I know some hospitals like that); and the other was a sleek, well-fed prosperous looking bay mare who had developed to a high degree the fine

An address presented to the biennial meeting of the Canadian Hospital Association, May, 1959. The author is chairman of the Ontario Hospital Services Commission.

art of appearing to pull when she actually was barely keeping the slack out of the traces. She was always half a step behind her mate. (I suspect that some hospitals feel that this applies to the Commissions.) Of course, with a heavy load the team was utterly useless. They never did learn to pull together.

It is highly important that the Commissions and the hospitals learn to pull together. Each must take its fair share of the load; and to do this successfully each must understand and accept its particular responsibility.

For example, the Commission in Ontario has stated again and again that it is most anxious to maintain the autonomy of the hospital, that it expects the hospital to manage its own affairs in a sound business-like fashion, making such decisions as are right and proper in any local management situation. It comes as a surprise, therefore, to be asked for permission to install a few panes of opaque glass in a nursery, or permission to pay for the dictaphone belts used by the staff in recording histories. Although these are extreme examples, they illustrate the kind of question that comes to us all too frequently. Surely these are matters for local decision.

A further example, and one with far reaching and much more serious implications, has to do with the bargaining situation. While I am familiar with the bargaining process in industry, I can only guess that in the hospital field it has not developed to the same degree. I presume that this has been due to the relative lack of union organization in hospital circles and to the marked variation in working conditions and wage scales from hospital to hospital across the province. There is no question, however, that hospitals are facing increased activity in this field and they must find a way to deal with it. From my point of view again the autonomy of the hospital must be maintained. Each hospital must bargain in good faith and attempt to obtain reasonable settlements with both hospital and community practice in mind. Only in this way can the hospital pull its full weight as part of the team.

Many hospitals have done this and they are to be congratulated. On the other hand, some hospitals have taken the attitude that since the Commission is paying the shot anyway why bother? These have granted—seemingly without too much argument—all of the demands put before them without regard to conditions prevailing in the local communities. Others have simply sent the union proposals in to the Commission, with a request that they be told what they should do about them. In my view in both these instances the hospitals have failed to exercise the privilege of management. Not only will hospital costs rise unduly but something, to my mind, much more serious will have occurred. A step will have been taken toward state control of hospitals — something to be deplored.

This brings me to the matter of budgets. It could be said that it is the budget which harnesses the hospital to the Commission. We have had an interesting experience with budgets in Ontario. On the whole, the hospitals have done a good job in their preparation, and I must say that I think our rate board has done an exceptionally fine job of reviewing them. In my opinion they have been extremely fair in the approach to the problem. They know much about hospitals.

Now, my understanding of a budget is that it is in effect a shrewd estimate of the probable cost of a given operation for the ensuing year. It is not an authority to spend, but a guide, which sets out realistically the expenditures that are felt to be necessary in each department if it is to function efficiently. It provides the costs upon which the per diem rate is established by the Commission.

It would seem to me to be elementary that the budget figure for any year should bear some relation to the experience for the preceding years with proper regard for trends in the cost of services and supplies. Some of our hospitals, I suspect, fearing decreased earnings under the plan and forgetting that precise information about their previous costs was available, put some strain on the harness. Experience will resolve these difficulties.

It also seems to me to be elementary and fundamental that once a budget figure has been established, every effort should be made by the hospital to live within it. It should not ask for a readjustment until sufficient experience has been accumulated with the unanticipated deviation to be certain that it cannot be absorbed in the present budget. With the present accounting and reporting procedures the Commission very soon will be aware if the hospital is in trouble. As for the other member of the team, I need not say, it is not its intention to ignore such a situation.

I am not unmindful of the problem of interest on capital debt, et cetera, at least in the province of Ontario. This is not a problem this year and I feel certain that some solution will be found before the end of the year. This is an area in which the hospital, the province and the federal authority are all involved and in which, in my view, they will need to pull together.

Staff Relations

There are other teams which should be examined. For example, there is the team composed of the doctor and the hospital. They have worked together so well for so long that one forgets that problem areas can develop. Staff relations in the hospital in which there are teaching beds and non-teaching beds, for example, present some difficulties. The lack of hospital privileges for many practising physicians in our larger metropolitan areas is another. The profession feels a great responsibility in these matters and in Ontario there is at present a special committee involved in a study of such problems. I am hopeful that their deliberations will bear fruit.

The doctor is also involved with the patient in an attempt to make the best possible use of the available beds. In many hospitals, admission and discharge committees are functioning well. In Ontario, the lack of domiciliary care accommodation tends to load up our long-term hospitals so that the chronically ill and convalescent patient is retained in active treatment accommodation. The admission and discharge committees are helping to a considerable degree to minimize the strain of this situation. I should say that welfare agencies are also co-operating.

I am not sure yet whether the patient is as co-operative as he might be but, on the other hand, when in practice I always had trouble trying to keep a patient in hospital. He always wanted to go home. In spite of paid up hospital care, I do not think that

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You and Your Association

André Duval, N.P.,
Quebec City, Que.

WHAT do we understand by the charter of an association and what are the duties and the responsibilities of the members of an association? I hope that this study will be of some use since it will lead us to think about daily actions so common that we hardly notice them. On the whole and notwithstanding appearances, small events may be of great importance since, by repetition, they fill our existence. A man, worthy of that name, should be able to explain rationally even his most familiar actions: why he eats three times a day, why he goes to his office, why he goes to church on Sundays and why he takes holidays, why he is a member of a club and how he spends his money.

To think of these things will first teach us that we do not live in quite the same way people before us used to do, and that even we do not live the way we used to live ten years ago. If you compare life to anything—let us say, a tree that grows, to the four seasons that follow each other, to a cathedral patiently erected by many generations of men—you will always find that life is a movement and that it is not exactly the same every time you think of it. For instance, you belong today to an association like the Canadian Association of Medical Record Librarians, you pay your annual fee regularly and everything seems to you very simple and natural. At the same time you may belong to either a service organization or a sports club. Do you happen to realize that in each case you enjoy a freedom that was paid for by a high price? There was a time when the right of meeting and of association was not recognized. This right had to be won, and the winning cost the freedom and the lives of many people. "Between the friends and the enemies of the right of meeting," wrote a French philosopher of the last century, "you find the whole thickness of the French Revolution."

Nowadays thousands of associations exist, but we should remain conscious of their significance. They are an important, even an essential, expression of our freedom as citizens. It is a right, but we should exercise it as though it were a privilege so that we never forget its meaning. Let us try to retain something of the spirit of those who maintained the right of meeting and association even against suspicious and tyrannical public authorities. We should realize that the existence of so many associations and clubs is a constitutional asset of our society, and that the best way to retain this asset is to have associations with as many members as possible, active and efficient. Otherwise we shall look like ungrateful people, indifferent to a very precious inheritance. I will not say, of course, that we can easily reach this frame of mind, being born and living under a regime of democratic freedom, but I consider that we ought to aim towards assimilating this juridicial concept of freedom of meeting and association.

Our clubs and associations are also an asset for social life. Through them, many people have a much more interesting life. None of us would like to live in a civilization where, except for the working hours of the day, each one is confined to home. Such a way of life appears very mean if we compare it with the kind of life that everyone can enjoy nowadays.

Now, in actual fact, what do we understand by an association? You probably know that there are many kinds of associations. Some are carried on for a pecuniary gain but these seldom keep the name of associations. They are known rather as societies or companies. Others are carried on without pecuniary gain and retain the name of associations. They are divided according to aim. In one group, you have charitable, scientific and literary societies, and in another, you find societies seeking the personal benefit of their members, such as club and professional syndicates. In civil law, the association is defined as "a convention by which two or more persons put together in a permanent way their knowledge or their activity for a purpose other than sharing a pecuniary gain," and "the statutes laid down by the founder or the founders and to which the members adhere" are the charter.

These two definitions show a characteristic feature of the association, that is to say, a certain communication of views among members. Before anything else, the association is an agreement and consequently it is of the nature of a contract. It means a willingness on the part of each member to be bound to the others towards reaching the objective for which the association exists. In the absence of such a common will, there is no association. Therefore it would be illogical to join any society if one remains indifferent to its activity and does not intend to participate in it. There may be differences of opinion on secondary matters but it is of the utmost importance that unanimity be made on the object of the common endeavour. To join an association for some reason unconnected with that object is cheating from the very beginning. It is better not to join than to do it under false pretences.

In other words, the members of an association who, when joining, have purely individual motives, are poor members. Even when a group has been formed for the benefit of its members, you must before all consider the collective benefit rather than the benefit to this or that one person in particular. You know very well, of course, that working for

(continued on page 96)

The author is professor of administrative law at Laval University, Quebec City. He gave this address at the convention of the Canadian Association of Medical Record Librarians in September, 1958. This article has also appeared in the "Bulletin" of the C.A.M.R.L.

15th C.H.A. Biennial Meeting

Montreal Milestone

Incoming president, Stanley W. Martin, receives the gavel from out-going president, Dr. D. F. W. Porter.

by Harriett Goldsborough

THE 15th biennial meeting held from May 11 to 13 marked a milestone for the Canadian Hospital Association. For there will never be a 16th biennial meeting. Henceforth the association will hold *annual* meetings. This was one of the major decisions made by delegates of the C.H.A. assembly. Many more interesting facts about the strides along the road of expansion taken by the association were heard by the 330 hospital people there. The registration, so it is said, is the largest ever recorded by the C.H.A. and delegates winged the many miles, from as far as Corner Brook and Port Alberni, to Montreal's Queen Elizabeth Hotel. The meeting was a success. One could tell even from the way eager delegates thronged into the meeting hall, from the way members sparked lively discussions and from the way everyone showed alert interest in the speakers. A simultaneous English-French translation service was wired up. (Everyone had a listen through the earphones whether he understood French or not). And the well ordered program—comprehensively arranged to cover varied topical subjects—rolled on its way.

Hospital insurance plans — their progress and their problems—provided a major topic of interest. In his keynote address the Hon. J. Waldo Monteith, Minister of National Health and Welfare, was the first to broach the subject. He lauded the co-operative relationship between the Department of National Health and Welfare and the Canadian Hospital Association; and he praised the association for its spade work in helping to bring hospital insurance into existence. Although national hospital insurance is still in its infancy there is every indication that it will be a success. "The plan," he said, "has come through its post-natal period with flying colours."

Mr. Monteith then went on to give a brief and succinct outline of the variations in, for instance, administration, financing, eligibility for benefits and scope of services, found in the individual provinces. He concluded by stating why the federal government did not favour depreciation and interest on capital debt as shareable items in the plan. (See page 36 for text).

The following morning's session was also involved with discussion of the insurance program, this time in relation to the work of the Department of National Health and Welfare with hospitals.

Department of National Health and Welfare

Dr. K. C. Charron, director of health services with the federal department, as chairman of this panel of government experts, introduced the topic and the speakers. Health, of course, is a provincial matter. Therefore, the two programs for strengthening hospital services — grants and hospital insurance — are channelled from the federal government to the provincial administrations to the hospitals. Dr. Charron listed the 14 divisions in the federal department, ranging from hospital design to research and statistics, which deal with specific services.

All offer consultant services. He, too, stressed the value of close and co-operative ties with the C.H.A.

Describing the hospital insurance program and just what it is meant to cover, Dr. E. H. Lossing, principal medical officer of health insurance, pointed out the difference in out-patient services existing in the various provinces. He made the federal interpretation of "out-patient service" clear, and defined what the federal government meant by "necessary nursing service" by citing example cases. He said that the line of demarcation between hospital care and medical services must be definitively drawn. The Act, he explained, excludes mental and tuberculosis hospitals and nursing homes for custodial care, but psychiatric units in general hospitals are not excluded. More and more provinces, he noted, were entering the chronic and convalescent hospital field, especially since the decline in tuberculosis sanatoria occupancy. It was important, Dr. Lossing emphasized, to ensure the proper distribution of beds for the chronically ill. In localities where the situation is difficult, such as Ontario, he suggested that certified nursing homes be included as an interim measure to relieve the demand until long-term needs have been computed. There have been, he optimistically concluded, no real problems or difficulties encountered, thanks to the hospitals' co-operative spirit.

Accounting and reporting aspects were dealt with by Dr. G. Josie and Dr. Lloyd Francis, principal research officers, Research and Statistics Division. Dr. Josie, in talking about the general data on hospital services and personnel required by the Department, urged the necessity of all hospitals' making complete, detailed and accurate returns. He revealed what information the government seeks in the forms in order to determine everything from the quality of care to the training facilities provided for hospital staff. The collection and compilation of this information, he explained, is valuable to all—leading to better patient care and better administration.

Also leading to better standards is the accurate and conscientious filing of the financial returns. Dr. L. Francis explained this operation of the Research and Statistics Division to the assembly. A financial schedule based on an audited financial statement is the objective here. Since the one set of forms is designed to aid local, provincial and federal purposes, these forms are flexible enough to meet the provincial variations. There will be some changes in the forms, but the work involved in completing them will not be appreciably greater. It is not the intention to provide financial returns which call for elaborate cost accounting.

Dr. G. E. Wride, principal medical officer, Health Grants, reviewed the areas covered and changes in the federal grants plan—construction, renovation, training of hospital personnel, and research. He assured hospital people of the government's continuing, and in many fields increasing, assistance — not only to hospitals themselves but to related community facilities and services as well. He reminded administrators to avail themselves of the provincial consultive and advisory services.

The rôle of the Research and Statistics Division in relation to the hospital's work was explained by Dr. J. W. Willard, director of that division. The division, he said, was a tool for evaluation, and a very useful tool, too, helping especially in the understanding of hospital relationships. He gave a brief resumé of the division's development and the scope of its work. He also discussed some of the projects and surveys in which the division is now engaged.

To round out the panel's comprehensive topics, disaster planning and supplies was included. Dr. E. J. Young, deputy director of the Civil Defence Health Services, brought us up to date on the progress and changes in this program. The original manuals on disaster planning, said Dr. Young, have now been made obsolete because of the increased nuclear threat. New manuals are being written and he recommends the booklet *Hospital Defence Plan* recently published at Ottawa. Because of the hospitals' key position and rôle in any disaster, he enumerated and elaborated on the four necessary requirements that must be filled by each and every one of them. Hospitals must have and exercise plans to expand their existing facilities, to be able to receive the casualties. Evacuation plans—for staff, patients, and the salvaging of some equipment—are a must. There must also be some means whereby, if a large number of hospitals are destroyed, the facilities may be replaced along with provision of beds for the thousands of casualties likely to occur instantaneously in a nuclear attack. A stockpile of supplies and equipment must be properly dispersed across the country as well.

How to meet the call for additional beds in times of disaster? How are the beds destroyed to be replaced? Dr. Young put forth two suggestions: (a) expand existing hospitals not in target areas; and (b) use transportable improvised hospitals. These improvised hospitals would consist of medical supplies and equipment for 200 beds, would serve as independent active treatment hospitals for casualties

On the scene were (l. to r.) J. N. Mainguy of the B.C.H.I.S., Victoria, B.C.; Dr. Paul Bourgeois, Notre-Dame Hospital, Montreal, Que.; D. W. Ogilvie of the O.H.S.C., Toronto, Ont.; and S. Victor Pryce, Calgary, Alta.

and would be housed in trailers or trucks, or set up in a suitable building (*i.e.*, a school). They might serve, too, as advance treatment centres close to the scene of disaster, as additional units for existing hospitals, or as supplies and equipment replacements for hospitals which had been evacuated or destroyed.

Provincial Progress

Detailed information about each provincial scheme was eagerly heard on Wednesday morning. Since last year's exchange of information on insurance plans proved so useful and valuable, the assembly's delegates were again prompted to bring each other up to date on the plan's progress, province by province. How has any development in hospital insurance affected hospitals or associations? This was the main question posed to each province.

British Columbia

The establishment of the national hospital insurance plan has had little effect on this province's plan, except for reducing the initial waiting period from 12 to three months, and for negotiating a reciprocal coverage arrangement with other participating provinces when residents move. The veterans' arrangements have been changed too —the federal department now pays the necessary co-insurance while the B.C.H.I.S. carries the rest of the cost. The federal plan has had no effect on B.C.H.A.-provincial government relations either. There have been no meetings with the cabinet or Minister since last year.

Alberta

Alberta fares much better, enjoying A1 relations with their provincial government. In Alberta, delegates reported, the Minister comes to the association. April 1, 1958 marked the inception of the provincial plan here, on a four mill equalized municipal assessment basis with a co-insurance of $1.50 to $2.00 a day, depending on the size of hospital. The province pays in monthly installments costs of operation, based on audited approved cost statements submitted by each hospital.

Since January 1, 1959, the Alberta government has assumed responsibility for all capital costs. New approved construction, too, is aided — within limits according to bed capacity — by the provincial government, as are equipment purchases. Equipment replacements costing up to $1,500 do not require government approval. Since April of this year also, long term and chronic care has been covered in the same manner as the active treatment hospitals; and effective May 1 this year, nursing homes or private hospitals will reduce their charge to patients to $1.50, and will be paid $4.50 by the province. Alberta's interest in the chronic bed situation is again revealed in the government's approval for construction of 50 homes for the aged (50 beds each) to relieve the nursing homes and chronic care hospitals. A government survey on utilization of all beds is under way.

Saskatchewan

There is a happy history of liaison in Saskatchewan too. "The impact of the federal plan," claimed the spokesman, "has caused little ripple on the tranquil waters of Saskatchewan." As of July 1, 1958, the government pays $5.00 for each out-patient service for accident cases within 24 hours. Some 50 per cent of superior ward revenue can be retained by the hospital and used for reducing capital debt, acquiring capital assets and paying interest. The government, however, has revised the Hospital Standards Act and has penalized hospitals filing late returns — which the Saskatchewan Hospital Association believes serves no useful purpose. Since the association has objected to the principle behind it, there is hope that this fine will be rescinded.

Manitoba

Expanded out-patient service marks off the changes in Manitoba, too. They now cover 20 listed benefits. A new ruling—stating that 20 per cent of the funds for new building projects must be raised in the community before government approval—is now being applied in this province. This might have been only 10 per cent had the Associated Hospitals of Manitoba been of one mind and suggested it to the government when asked for a suitable percentage. The moral of this sad tale, warned the delegate, is that hospital associations should have a united opinion and give it when asked by the provincial government. Depreciation is allowed—if it is funded and used to retire capital debt payments.

Ontario

The plan for Ontario meant a new adventure. This province has a combination voluntary and mandatory system that has led over 90 per cent of the population to enroll. Individual rates for each hospital are worked out by the Rate Board, and differential charges are indicated by the independent Ontario Hospital Services Commission. Emergency services have a $5.00 flat payment, paid on the basis of claims submitted on a per diem basis.

Ontario provides no specific settlement for existing capital debt or depreciation on buildings, but the provincial premier has made special grants for debt retirement available this year, as well as stepping up out-patient service payments by $1.50 per visit. However,

Intent on the assembly's business. Eugene F. Bourassa, Dr. A. L. Swanson, and Dr. R. J. Easton, who vigorously voiced Saskatchewan's opinions.

Dr. John Wong, Doctors' Hospital, Toronto, Ont.; Dr. Paul L'Heureux, St. Boniface Hospital, St. Boniface, Man.; Eugene F. Bourassa, Regina, Sask.; and Fred Whittaker, Western Memorial Hospital, Corner Brook, Nfld., chat between sessions.

Sister Ricard, Hôtel-Dieu Ste-Hyacinthe, Ste. Hyacinthe, Que.; Sister Sainte-Marie-Madeleine, Hôtel-Dieu de Montmagny, Montmagny, Que.; and Sister Gertrude de Sacré Coeur, Hôpital Notre-Dame de l'Espérance, Ville St-Laurent, Que.; look over the list of nominated officers.

here provincial and federal participation in hospital cost has created a new problem for Ontario—the municipal governments are withdrawing their support.

Grants for capital construction remain on the "matching" basis, but may be extended, as the commission is at present examining the bed requirements and may request that different standards be established. The difficulty in Ontario, too, is connected with chronic and convalescent care. Where to draw the line between convalescent and custodial care?

Quebec

The Quebec hospitals are in an alarming financial situation, stated the spokesman for this province. The operating Public Assistance Act allows only $10.50 to hospitals whose current cost of operation is from $18 to $19 a day. The newly formed Quebec Hospital Association has submitted a detailed report to the provincial authorities. As yet Quebec has no definite statement to make, but the association is convinced that some interesting modifications for hospitals will come at the next session of the provincial parliament. Quebec is still hoping.

New Brunswick

Plans here may be altered by the time the program comes into effect on July 1 of this year. The premium method of financing has been objected to, the municipalities who are to be responsible for collecting these premiums are unhappy, and the response to registration has been disappointing — only 45 per cent of the population, due, New Brunswick's delegate believes, to the poor publicity the plan has received in his province. A commission has been appointed and it includes one hospital administrator, Mother St. Georges. Unfortunately, the contact between the association and the government can only be described as spasmodic.

Under this plan depreciation on equipment will be allowed at 6¼ per cent if funded, but there will be none allowed on buildings, nor can the differential be retained, as the commission will fund this source of revenue for capital assistance. "In New Brunswick," the delegate feared, "the hospital trustee will be but a stark skeleton, thinly covered with platitudes about autonomy."

Nova Scotia

Nova Scotia has now only three months' experience with her plan and is happy with it. It parallels Ontario's plan, providing all residents with in-patient care and the necessary ancillary services. Out-patient services cover accident cases up to 48 hours, and x-ray and physiotherapy facilities where available. Both hospitals and public are pressing for full out-patient coverage. The differential charge is set by the Rate Board (50 per cent may be retained) and 6¼ per cent funded for depreciation is allowed. For capital finance, loans up to 50 per cent of construction costs, exclusive of provincial and federal grants, can be solicited by the municipality. New equipment costing over $500 must be approved by the independent Commission.

Prince Edward Island

Here a plan is announced for October 1 of this year. A commission has been appointed and the hospital association was told what was in the Act — little discussion having been courted. Prince Edward Island's plan, not yet officially announced, is supposed to be one based on voluntary premiums and similar to the Ontario scheme. What happens to those who do not enter the plan is not known. Will depreciation be allowed on buildings? The delegate thought not, but on equipment, yes, if funded. Prince Edward Island, he con-

L. to r. are Therese d'Aoust, St. Mary's Hospital, Montreal, Que.; Sister M. Justina, Johnson Memorial Hospital, Gimli, Man.; and Sister Ste-Hélène de Rome, Misericordia Hospital, Winnipeg, Man.

cluded, was one of the provinces with a high ratio of beds per population.

Newfoundland

The easternmost province finds her plan, initiated on July 1, 1958, working well. It is financed out of the province's general consolidated fund, from which the hospitals are paid an all-inclusive rate. Certain out-patient services — including x-ray, laboratory tests and physiotherapy—are included, and capital equipment (but not construction) is covered. A real problem here is over-crowding. The plan is premature, in the opinion of a speaker from Newfoundland, since the province does not have the facilities to cope with it.

Reports and Business

The Canadian Hospital Association has indeed entered a new phase. This was easily discovered from listening to the reports on the association's growing and varied activities.

Executive Director

Both the president's report (see page 41) and that of the executive director, Dr. W. Douglas Piercey, centred on the association's growth; and its new energies were illustrated. Dr. Piercey drew attention to the C.H.A.'s liaisons with numerous government departments, agencies and associations in the health field — such as the Civil Defence Health Services Division of the Department of National Health and Welfare, the Defence Medical and Dental Services Advisory Board, the Canadian Standards Association, a sub-committee in developing specifications for hospital textiles, the Joint Committee on Nursing, and, for education in hospital administration, the School of Hygiene, University of Toronto. Committee work for the association—concerning finance and building, education, accounting and statistics, and accreditation—has been at a peak this year too.

The executive director, in discussing the publications, urged hospitals not to be shy in submitting items, pictures or articles to *Canadian Hospital*, and thanked administrators for their co-operation in amassing the information which makes the directory so valuable. He also threw in a plug for the C.H.A.'s library services.

He continued to assure hospitals that their boards of trustees have not become ineffective with the coming of national hospital insurance. Only operating cost worries have gone and there remains a big job of management for them. "Boards," he said, "are still responsible at the local level for ensuring that the operation of hospitals is conducted on a sound, businesslike basis." Local leadership *is* essential; and the central government not only wants local participation in administering the insurance plans, but welcomes it. Nor are, Dr. Piercey went on, women's auxiliaries pushed into insignificance by the national scheme. Their fund-raising activities, their public relations campaigns, their volunteer services are more important than ever.

In summing up, Dr. Piercey listed six of the association's plans for forging ahead: strengthening the C.H.A. as a truly national organization; maintaining close contact with the Department of National Health and Welfare; expanding educational programs (particularly institutes and a course for head nurses); securing funds to embark on a stepped-up program of public relations for individual hospitals, provincial associations and the national association; completing the C.H.A. headquarters building; and strengthening communications between the member associations and the national office.

Treasurer's Report

Financially, it was the best year ever for the C.H.A. Dr. John E. Sharpe of Toronto, as treasurer, reported the success of the new membership fee system adopted in 1957 and paid in 1958. Both extension courses (Hospital Organization and Management and that for Medical Record Librarians), financed with the aid of the W. K. Kellogg Foundation, showed deficits. But this was only to be expected since the courses underwent extensive revisions this past year. However, from now on both will be self-supporting as intended from their inception. The continuing assistance of the Sun Life Assurance Company, and the Blue Cross Plans toward the secretarial work of the association has, of course, been most welcome and appreciated, concluded Dr. Sharpe.

Publications

The publications have had a good year, too. Charles A. Edwards, business manager of the C.H.A. publications, reported on both the journal's and the directory's success in advertising and in editorial matter. He drew attention to the journal's new cover, mentioned that an independent publishing firm is planning to introduce another hospital magazine, and thanked *Canadian Hospital* readers for their loyalty.

Building

S. W. Martin, in announcing the completion of the building committee's work, described how the new headquarters building would look. The property, 25-27 Imperial St., Toronto (north of Davisville, off Yonge), has been purchased, plans have been drawn up by architects Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside, Toronto, and tenders have been called and awarded. However it was decided that the three-storey

brick building should be built to provide for the addition of a fourth floor some time in the future. This type of structure was felt to be a much better investment and a vote was called to raise the original allottment of $175,000 to the sum of $190,000. Enthusiasm ran high and a motion from the floor upped the amount to $200,000. The Associated Hospitals of Alberta and the Ontario Hospital Association have offered to underwrite a mortgage of $150,000 at an interest of 5½ per cent per annum. C.H.A. staff, Mr. Martin summed up, should be released from their present cramped and crowded quarters and settled in their new home by November 1959.

Accreditation

Hospital people heard about the work and growth of the Canadian Council on Hospital Accreditation from Dr. J. B. Neilson. He told of the Council's first inaugural meeting in Toronto in January 1959 when the whole scheme was lauded by the Hon. J. Waldo Monteith and received desirable publicity. A guide for field representatives has been published and the Council has made great strides in developing and distributing official Canadian documents. Accreditation Standards have been published in both English and French and can be bought by non-accredited hospitals for $1.00, and for 50 cents each if ordered in lots of five or more. Accredited hospitals will be receiving them free.

Dr. Neilson also announced that it was hoped that the Canadian revision of suggested medical staff by-laws, rules and regulations would be available in early 1960. A bilingual certificate that can be renewed without returning it to the Council is about to be produced also.

Standards of accreditation should be high: hospitals must strive to *reach* them. But the setting of standards forms one of the Council's major problems. Generally the Council is opposed to changes in standards without adequate reasons. Any change must pass through and be studied carefully by the Council's Committee on Standards. A new step to be welcomed is the accreditation of mental hospitals. This can be done once the decision on what type of standards should apply has been made.

Many other positive forward steps have been taken by the Council this year. Surveyors have been insured against libel or slander suits and against accidents or injury. A new field representative, Dr. D. D. Campbell, Hamilton, Ont., has been added, and relations with the Joint Commission on Accreditation of Hospitals are all good-will now. The great number of hospitals seeking accreditation has been gratifying to the Council. Even smaller hospitals of 25-50 beds, the problem children of accreditation, rejoiced Dr. Neilson, are making more inquiries.

But it must not be forgotten that to date only 60 per cent of eligible hospitals in Canada are accredited. We must do more reaching. Expenses of the Council rose this year, but this was only to be expected because of increased travel costs, more Council meetings, incorporation and legal fees, the insurance for surveyors and the printing costs involved in the production of the new Canadian forms. To meet these commitments the payments of constituent members have been increased to $4,000 per seat, effective January 1960. On the whole Dr. Neilson presented a healthy and encouraging picture of accreditation activities.

Education

The activities of the Committee on Education, summarized by Dr. G. Harvey Agnew, revealed steady growth and expansion also. The association's extension course, Hospital Organization and Management, can point with pride after seven years of operation to 298 graduates and to the 67 students now enrolled in the second year. Major revisions have been made in six lessons and will continue to be made as the *Canadian Hospital Accounting Manual* is revised, and as the interest in chronic diseases, convalescence and geriatrics increases. This year the summer session is to be held at Toronto.

Medical record librarians are still in demand and the extension course for them has graduated 115, 56 of whom have written the registration examination of the Canadian Association of Medical Record Librar-

Tuesday afternoon saw these speakers participate in a panel on nursing. L to r.: Ella Howard, New Mount Sinai Hospital, Toronto, Ont.; Sister M. Felicitas, St. Mary's Hospital, Montreal, Que.; Alice Girard, St-Luc Hospital, Montreal, Que., who chaired the session; Helen K. Mussallem, Canadian Nurses' Association, Ottawa; and Hazel B. Keeler, University of Saskatchewan School of Nursing, Saskatoon.

Delegates came from coast to coast. Seen here are Neil D. Maclean, Charlottetown, P.E.I.; Harvey E. Taylor, Port Alberni, B.C.; C. E. Barton, Regina, Sask.; and John B. Davis of the Dominion Bureau of Statistics, Ottawa.

Dr. Angus C. McGugan is congratulated by Dr. Porter on receiving the George Findlay Stephens Memorial Award.

ians. Some 35 are expected to graduate this summer when they complete the intramural sessions. From August 31, 1958, both H.O.M. and M.R.L. courses have been self-supporting, as planned when they were initiated with the aid of the W. K. Kellogg Foundation.

Dr. Agnew went on to tell of the value of institutes and workshops as continuing education programs for hospital personnel across the country. He described the steps already taken to develop a program, in co-operation with the Canadian Nurses' Association, to train head nurses and assistant head nurses in supervisory and administrative skills. It is expected, he said, that this course, to be composed of nine or ten home study lessons and five-day workshops, will not be offered before the fall of 1960.

Accounting and Statistics

In reporting for the Committee on Accounting and Statistics, Walter W. B. Dick, its chairman, outlined the committee's accomplishments from its inception—the planning and publication of C.H.A.M., its interim revision draft, the 1958 supplement and the French editions. He also explained the delay of the revised second edition which in retrospect was a wise decision, and told of the working parties and technical conferences between the federal government and the provinces last October.

What of the committee's future? Mr. Dick recommended that the whole committee should meet more frequently to make its work more effective. As an alternative, a small technical sub-committee of five or six people might meet every month or two, and provide the full committee (composed of more than 20 people) with data by mail. He also suggested that a greater amount of administrative time at the C.H.A. head office be devoted to hospital accounting. In concluding, Mr. Dick recommended and lauded such accounting institutes as those held in the Maritimes. (See "Control Through Accounting", *Canadian Hospital*, May 1958).

Constitution

S. V. Pryce, speaking for the Constitution Committee, proposed a recommendation for amendments to the association's constitution, suggesting that the committee study them further, and report at a later date.

Consolidated Billing

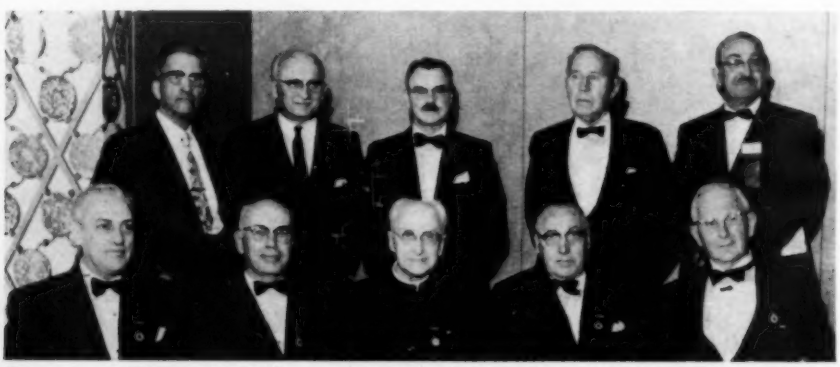
The board proposed a change in the method of billing for accreditation. In order to support the Council's activity and to put accreditation financing on a proper basis, a fee of 17 cents a bed in the dues structure for 1960 and 1961 for constituent members was voted. This means an increase in the total estimate only for Ontario and Saskatchewan, with some decrease for other provinces.

Hands Across the Border

Greetings were brought from the American Hospital Association by Ray Amberg, the A.H.A. president. He had asked to be present, he said, especially since there was such a lively interest in the United States in what Canadians had to say on hospital affairs — particularly on hospital insurance.

Hospital matters in the two countries were of mutual interest, for Canadians listened attentively to the frank and open talk given by Kenneth Williamson, associate director of the A.H.A.'s Washington Service Bureau, on Monday evening. Mr. Williamson explained how this liaison section of the A.H.A. got their Congress actively interested in promoting hospital legislation, and elaborated on the ins and outs of lobbying for group interests in Washington—illustrating their "positive thinking" and public relations campaigns. The A.H.A. and its bureau was working hard, he said, to develop an attitude in Congress whereby no administrative department, senator or representative thought of hospitals or

(continued on page 76)



Front row: The past presidents who received pins: (l. to r.) Dr. J. Gilbert Turner, Montreal, Que.; Dr. Angus C. McGugan, Edmonton, Alta.; Rev. Georges Verreault, Montreal, Que.; A. J. Swanson, Toronto, Ont.; and R. Fraser Armstrong, Kingston, Ont.

Standing are those who presented the past presidents with their pins: (l. to r.) Judge Nelles V. Buchanan, Edmonton, Alta.; Dr. G. Harvey Agnew, Toronto, Ont.; George Bourke of the Sun Life Assurance Company of Canada, Montreal, Que.; Dr. Lorne C. Gilday, Montreal, Que., and Dr. D. F. W. Porter, Vallée Lourdes, N.B.

Resolutions

Adopted at the 15th biennial meeting of the Canadian Hospital Association, held in Montreal, Quebec, May, 1959.

Non-member Hospitals

WHEREAS certain Canadian hospitals have never held membership in the member associations of the Canadian Hospital Association, or having held such membership, have withdrawn from active participation in such associations,

AND WHEREAS non-support of member associations of the Canadian Hospital Association means non-support of the national association, financial and otherwise, with the consequent result that the active hospitals carry the financial responsibilities for certain activities of the Canadian Hospital Association,

THEREFORE BE IT RESOLVED that, in selecting candidates for educational programs conducted by the Canadian Hospital Association, preference be given to those hospitals which pay membership fees to active members of the Canadian Hospital Association.

Revision of Association By-laws

WHEREAS frequent references have been made during this meeting to the need for revising the governing by-laws of the association,

BE IT RESOLVED that the incoming board of directors be instructed to study the urgent necessity of a general revision of the governing by-laws of the association, especially as they relate to representation by active members and to procedures for the nomination and election of officers and directors at meetings of the assembly,

AND BE IT FURTHER RESOLVED that any recommendations resulting from this study be sent out to all active members well in advance of the next regular annual meeting of the assembly.

Accreditation of Nursing Schools

WHEREAS the Canadian Nurses' Association is at present conducting a pilot project for the evaluation of schools of nursing in Canada,

AND WHEREAS a program for the accreditation of schools of nursing in Canada may be deemed desirable as a result of the findings of the pilot study,

THEREFORE BE IT RESOLVED that if such a program for the accreditation of schools of nursing is to be inaugurated that it be under the control of a joint committee of the groups primarily concerned with the education of nurses and that the Canadian Hospital Association should be a member of such a joint committee.

Medical Services in Hospitals

WHEREAS many hospitals in Canada have traditionally engaged the services of physicians in hospitals as physiatrists, psychiatrists, and as physicians in charge of the medical care of chronic patients, et cetera,

AND WHEREAS the federal government has repeatedly given assurances that the introduction of national hospital insurance will not disturb the traditional patterns of hospital operation,

AND WHEREAS it has now been indicated to many hospitals that the federal authority is not prepared to recognize the costs to the hospitals in the payment of physicians engaged in these capacities in the same way that they do to accept the costs of similar services provided by other specialists such as radiologists, pathologists, et cetera,

AND WHEREAS under existing provincial hospital insurance programs no other funds are available to hospitals to pay these costs,

THEREFORE BE IT RESOLVED that strong representations be made to the government of Canada to recognize these traditional patterns of hospital operation and to share in their cost.

Out-Patient Services

WHEREAS Section 7 (3) (J) of the regulations under the Hospital Insurance and Diagnostic Services Act provides that gross earning accruing to the hospital for the provision of certain hospital services, such as diagnostic radiological examinations, clinical laboratory services, physiotherapy and other services provided to out-patients less certain allowances, must be deducted from estimates of expenditures which form the basis of calculating the per diem rate for services to be provided under a provincial hospital insurance plan;

AND WHEREAS under existing accounting practices such gross earnings must include charges for services provided to indigents and other persons whose accounts eventually must be classified as "free work" or uncollectable and for which no actual monies will be received by the hospital;

AND WHEREAS the strict application of such a regulation will result in actual financial deficits accruing to many hospitals

BE IT THEREFORE RESOLVED that strong representations be made to the Department of National Health and Welfare, pointing out the difficulties which will develop through the application of this particular regulation, and urging suitable revision whereby this financial hazard for hospitals may be removed.

Accreditation of Schools of Radiological Technicians

WHEREAS the Canadian Society of Radiological Technicians in conjunction with the Canadian Society of Radiologists is currently preparing a program of accreditation of schools of radiological technicians conducted in hospitals in Canada,

BE IT THEREFORE RESOLVED that such a program should be controlled by a joint committee of the groups primarily concerned, and that the Canadian Hospital Association be a member of such a joint committee.

Thanks and Appreciation

WHEREAS the past and present activities of the Canadian Hospital Association have been materially aided and its broad objectives advanced by the active interest and support of many individuals and organizations,

AND WHEREAS the holding of the fifteenth biennial meeting of the association in Montreal has been facilitated and the conduct of the association's business expedited by assistance from many people,

THEREFORE BE IT RESOLVED that the assembly go on record as ex-

(concluded on page 82)

Under a Hospital Insurance Plan

A New Era—A New Way

S. W. Martin,
Toronto, Ont.

THAT the public's attitude towards hospitals in this new era will change, cannot be denied. Hospital people have already encountered some symptoms of change over the past few months. Thus the challenge we must face is whether we can adequately foresee and recognize the more important changes, and whether we can remodel or revise our existing programs to offset criticisms and to channel public support where it is most needed.

It takes little imagination to see that, with the introduction of the government sponsored plan of hospital insurance, hospitals become the active interpreters of this new broad program of benefits. Not only are we required to provide the hospital services which are available to all on payment of a premium, but whether we like it or not, we become mediators in situations arising from any of the plan's limitations and the public's misunderstanding of the plan's general and specific objectives. All of these affect our hospitals' public relations. How far can the crystal ball help us to foresee such attitude changes?

Obviously, one of the greatest changes is the method by which our general operations are financed. For many years hospital charges for services were determined by the governing boards, and were adjusted from time to time. By and large, the traditional pattern has been one of charging a fixed amount for the type of bed accommodation, supplemented by additional charges for so called extra services. Patients could never know what their ultimate bill would be and, in retrospect, it appears to speak well for the confidence placed in hospitals by the public that most bills were paid without too many complaints. Since the inception of the plan, hospitals receive reimbursement for services rendered through submitting a detailed budget setting forth all estimated spending for the year. When the budget is reviewed and accepted by the commission's rate board, a per diem rate for so called standard ward care is established which automatically governs payments for insured patients at the hospital. This is an "all-inclusive" rate—the old system of bed charge plus extras is scrapped. Because the commission has by regulation directed that the rate for all patients not insured shall not exceed the rate paid on behalf of insured patients, it is obvious that all patients are paying on the "all inclusive" rate basis. This in itself creates a challenge to explain to everyone why there suddenly appears to be a marked increase in hospital charges. Undoubtedly, most people familiar with hospital practice have thought of hospital rates in terms of the room charge only; hence the admitting officer will see many raised eyebrows when she tells the self-paying patients that their service charge will be $17.00 or $18.00 per day for ward accommodation and higher for semi-private or private rooms. There is, therefore, a need for each hospital to begin explaining this change through newspaper interviews, special pamphlets, addresses to public groups, and any other means of communication to deter resentment and criticism. I feel that if this story is intelligently told in each community, it would not only assist the hospital over the hump of misunderstanding when patients arrive at the hospital, but also would give an incentive for everyone to enrol in the plan at once. Every trustee and administrator should take immediate action.

I can also foresee a continuing responsibility for each hospital to interpret intelligently to its community changes in its operating costs. Insured patients are not directly concerned, but one can quickly visualize the problems that will arise when subscription rates for subscribers are changed. We have been informed that present subscription rates are expected to hold for two years at least, and perhaps longer, but everyone is acutely aware that hospital operating costs will continue to increase for some time. Obviously, we will be paying higher salaries and wages to our personnel. The work week for many hospital people will have to be shortened to correspond with those of other workers of the community. All these factors and others will continue to exert a relentless pressure for higher operating costs. Everyone likes to receive more money, but everyone resents having to pay out more for services and commodities. This is particularly true insofar as the general public and the hospital field are concerned. Hence we have a responsibility for giving imaginative education to our community about what is happening at the hospital that calls for increased spending. We must point out to people that if their hospital services are to be maintained at a high level of efficiency, ready to meet their demands day or night, such service requires an increasing number of dollars. By keeping people informed of changes as they are occurring, we can create a climate which will be conducive to a better understanding of the revisions which will inevitably have to be made in terms of the prepayment plan.

Tied in with the changes in operating costs is the tendency toward making even greater use of hospital facilities for diagnosis and treatment. I have frequently seen references to crowded bed conditions—beds in corridors, et cetera—which obviously point up a greater use of limited space and equipment. Much remains to be done in keeping people informed about the facilities of various kinds being provided at their hospital. This can be most important

(continued on page 56)

The author is executive secretary-treasurer of the Ontario Hospital Association. He is also the president of the Canadian Hospital Association.

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when it is related directly to the need for expansion.

It is well to note, too, that almost all of what has been said about revamped costs of operations applies equally to properly informed medical and general staff. The lack of intelligently interpreted and up-to-date information for these people can produce even worse effects for the hospital than an uninformed community. A really effective job of informing members of staff about demands being made upon the various service departments will have to be done if we are to solicit the medical staff's assistance in seeing that the best possible use is made of the hospital's services.

That this story has to be carefully planned and told is almost a must if a logical balance in its emphasis is to be achieved. We must program our story so that costs of operation do not become the all-embracing interest, but rather the by-product of providing the standard of care in the hospitals which our citizens expect and, in fact, often demand. In this connection I wish to quote Dorothy Percy, chief nursing consultant, Department of National Health and Welfare, speaking to those attending the annual meeting of the Registered Nurses' Association of Ontario in Toronto in the spring of 1958. In speaking to the question of the provincial plan, she said:

"There is one thing which we shall all need to keep in mind. With financial assistance being geared to operating costs, the efficiency of a hospital will become very important. Hospital commissions will, for the first while at any rate, and understandably so, be much preoccupied with what, for lack of a better term, might be called 'hotel management' of hospitals.

"This would seem to place a special responsibility on the nursing staff. Who better than they can help preserve the heart and soul of the institution and provide stability, especially during the trying preliminary period when patients, no less than hospital authorities, will be making many adjustments. As a thoughtful, experienced nurse said recently: 'Nurses must help the authorities remember the reason for the existence of a hospital; that the services rendered in a hospital are for a person, given to a person, by a person, and that the hospital does not fulfill its function where the personal factor is overshadowed in the pursuit of organization'."

While every consideration must be given to careful management principles in every hospital, trustees and administrators must be ever alert to keep in the forefront of the image they portray to their community the vital point that the *raison d'être* of the hospital is good care for its patients.

The Ontario Hospital Insurance Plan is designed to prepay protection for its subscribers against the cost of ordinary hospital services, but it does not make provision for the creation of facilities in which such care is to be given. Payments to hospitals meet all normal operating costs, but do not provide capital funds for extending existing buildings or the erection of entirely new ones. Hospitals will receive some allowances for depreciating equipment, but this will only be on an acquired cost basis and hence any upward trend in costs will mean that the hospitals will still have to find additional capital funds to maintain highly efficient services. The provision of buildings themselves, including boiler plants and elevators, remains almost entirely a local responsibility. Both provincial and federal governments continue to assist through bed grants of at least $4,000 per bed, but this still leaves a large share to be raised locally. It is here that our story has to be clearly told and understood if the voluntary hospital, locally owned and locally operated, is to survive. Hospitals over the years and particularly since the second world war, have enjoyed a very generous measure of support from their local citizens, either from direct donations or through municipal debenture issues. The new challenge facing hospitals is how to maintain sufficient interest in the services they provide so that business organizations, service clubs, individual citizens and local municipal councils still feel close enough to give as much financial support in the future as in the past. Unquestionably some administrators have already felt the change in public attitude that suggests that since governments are providing a hospital insurance plan, there will no longer be any need for continuing private philanthropy for hospitals. If we are serious in our contention that a hospital system is best that identifies itself as a community service and in which hospitals are operated by community minded citizens, we will have to indicate aggressively that improvements in our ability to provide extended services to the communities is entirely in their hands. This may not be an easy task. It means we will have to work hard and continuously to identify ourselves as a vital part of the every day life of our community.

Now, for the first time, protection for care in convalescent or chronic illness facilities is to be available. Most of us have been so busy building up facilities to meet the needs of people for general active treatment care that in many communities there are no facilities to provide for extended illness care. Many advantages may be cited to point out why such facilities should be developed as part of the general hospital within the community. Obviously, the problem will have to be solved, but are we prepared to begin planning extensions to meet the challenge, or do we wish to turn this over to some level of government?

Trustees and members of advisory boards of hospitals must clearly understand all that is involved for their own hospitals in the workings of the government plan. Evasive or indecisive answers to questions raised by people in the community can quickly be interpreted as a lessening of the managing responsibilities at the local level. Let us not make the mistake of interpreting everything connected with this new development as being entirely restrictive. More than ever before, the management of our governing boards must be active and progressive and be interpreted to the community as such. To accomplish this boards must get the most reliable, comprehensive, accurate and up-to-date information available about all operations connected with their hospitals, and the trustees and governors must continue to be outstanding individuals who are prepared to give their counsel and experience to the work of the hospital. They must represent the hospital to the community and be proud of the rôle it plays in the life of all citizens.

The problem that many hospital boards have faced—that of soliciting financial assistance for operating deficits—will now be a matter of the past. In many ways this has always been a negative endeavour but it has demanded a

(concluded on page 92)

Provincial Notes

New Brunswick

It has been suggested that St. Quentin needs a new hospital, and special consideration for this project has been urged. "Nous avons un besoin urgent d'un nouvel hôpital, car nous sommes à 67 milles de l'hôpital, le plus proche." This was the opinion expressed by deputy Fred Somers at the provincial legislative assembly.

The Miramichi Hospital Club (Newcastle) has presented the hospital with a 72-cup urn. The club has also set aside $1,000 which will be used to furnish a nursery in the new wing when it is complete.

Quebec

The contract has been awarded for a few nurses' residence at Hôpital du Saint-Sacrement in Quebec City. Plans, by Pierre Rinfret, Sillery, call for a seven-storey, L-shaped building with swimming pool.

A gastro-intestinal research laboratory has been opened in the department of experimental surgery, McGill University, Montreal. The laboratory is part of the experimental surgery department established by a grant from a pharmaceutical company. Dr. D. R. Webster, director of the department of experimental surgery, is surgeon in chief at the Royal Victoria Hospital, Montreal.

Ontario

A $2,305,000, expansion program has been announced by the advisory board of St. Joseph's Hospital, London. Included in the plans are a seven-storey addition which will provide 170 more beds; a four-storey addition to contain x-ray and out-patient departments, as well as a large lecture hall; and another four-storey addition which will link the new building with the old north wing and provide an expansion of surgery, maternity, laboratory, paediatric and kitchen facilities. There will also be improvements to the physiotherapy department. Architects are Watt and Tillmann of London.

This year the first half of a major expansion program at the General Hospital of Port Arthur, Port Arthur, will be complete. Four nursing floors were added to the north-west wing; one of them provided modern isolation facilities. There were also new elevators, a new boiler system, kitchen, laundry and stores. The final half of the program will soon be begun. Under this plan there will be new administration offices, admitting office and medical records branch. Operating and delivery rooms will be renovated and expanded; a morgue and autopsy facilities will be provided; and the x-ray department will be enlarged. There will also be a new emergency department and additional staff facilities.

The board of directors of the Stratford General Hospital in Stratford has decided to hire a hospital planning consultant to prepare a report on expansion needs.

A program of expansion and modernization of services at the Porcupine General Hospital in South Porcupine is being considered. Rudolf Papanek and Associates, Timmins; are the architects engaged for the preliminary work. Present plans call for a one-storey wing with a full basement, designed in such a way that a second storey could be added easily.

The Atkinson Charitable Foundation has granted $2,950 to the Manitouwadge General Hospital in Manitouwadge for the purchase of equipment—oxygen tent, portable autoclave, microscope, blood bank, refrigerator, suction machine, therapy tent, bassinet and wheelchair. No date has been set for the hospital's opening.

A recent fire at the Kingston Military Hospital, Kingston, did not delay its opening. The fire, which broke out in the medical inspection room, caused several thousand dollars worth of damage. However, patients at the old military hospital were moved into the 2½ million dollar building on schedule. The hospital accommodates patients from army, air force and navy.

A central Red Cross blood depot has been set up at Westminster Hospital in London. The depot will collect, process and distribute blood donations throughout the area. On the staff are three registered nurses, seven technicians trained in haematology, nurses' aides and a number of transport drivers.

Kipling Acres, Metropolitan Toronto's new $1,700,000 home for the aged in Etobicoke, has welcomed its first residents. Citizens from many nursing homes will be moved to the 265-bed building in the suburbs. At Kipling Acres they will find a full program of arts and crafts, musical concerts and many other recreational activities.

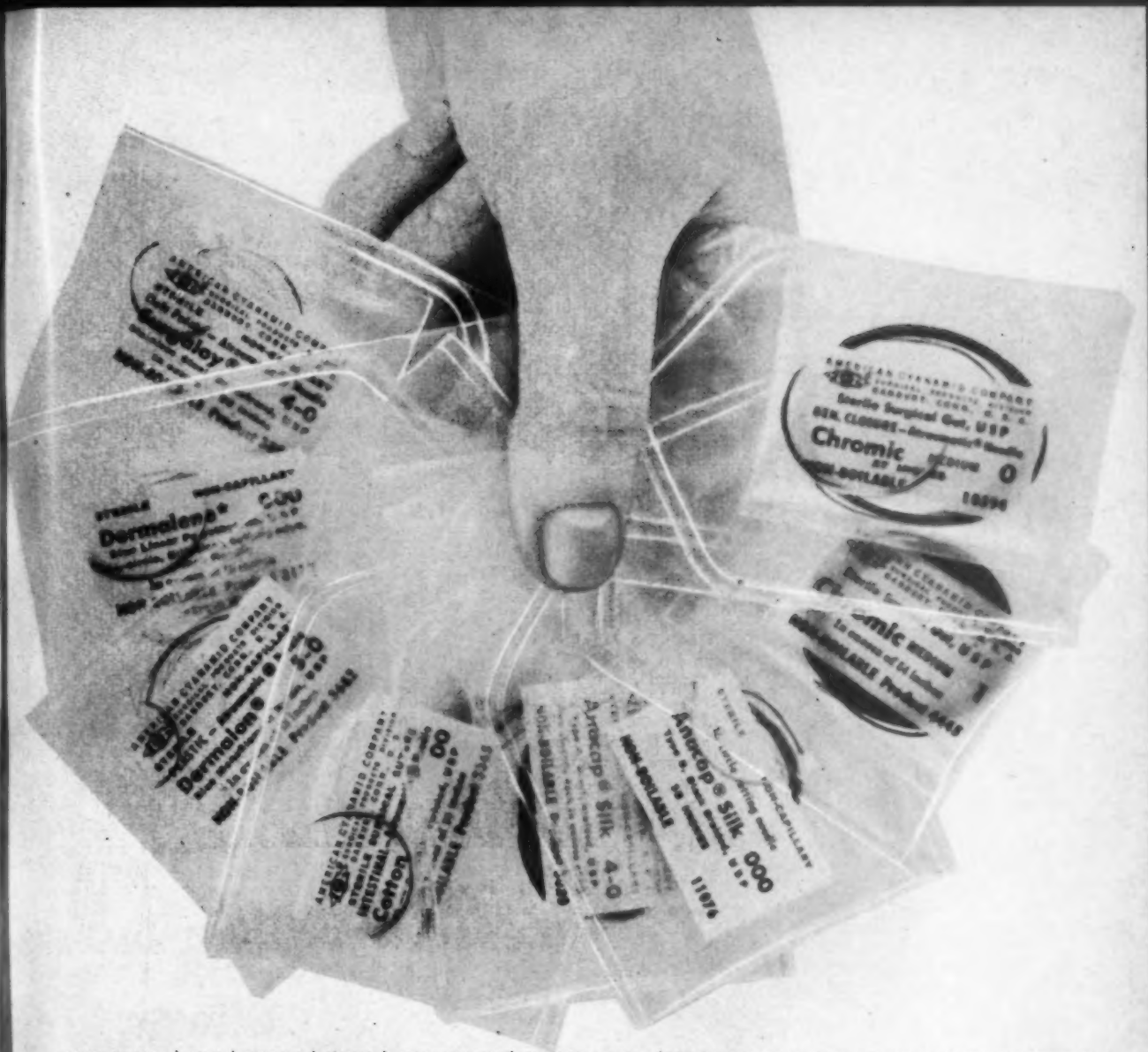
The Toronto East General Hospital recently opened two new six-storey wings — a $4,500,000 addition for a rapidly-growing hospital. The J. Leslie Price Pavilion and the Governors' Pavilion provide 233 beds plus 32 bassinets in a new nursery. The semi-private rooms and four-bed wards are tastefully decorated in warm, soft colours. The addition also means seven more operating rooms (wired for closed-circuit television), as well as new obstetrical, out-patient and admitting departments. Besides this, there are new residences for nurses and interns, including apartments for married interns. Now, too, the hospital can boast about its up-to-date medical records department, doctors' lecture room, student training rooms, cafeteria and large, well-equipped laundry.

Two of the oldest Houses of Providence in Ontario are to be replaced. At Guelph there will be a new home replacing an old wing of St. Joseph's Hospital which was built in 1861. It will accommodate 111 aged men and women who are not active treatment cases. In Kingston there will also be a new home for 164 people. Two grants by the provincial government will help finance construction.

Manitoba

Tenders have been called for an addition to the Reston Medical Nursing Unit in Reston. Architects are Smith, Carter, Searle and Associates, Brandon and Winnipeg.

(continued on page 60)



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Provincial Notes
(concluded from page 58)

Work will begin this summer on an $800,000 building and modernization program at the Victoria General Hospital in Winnipeg. An extra floor will be added to the present building, increasing it to six storeys and adding 41 beds. And an older section of the hospital will be modernized. The hospital also expects to undertake the construction of a new wing—to cost $1,500,000—within the next five years.

Plans for a physiotherapy and occupational therapy unit for the new extended treatment centre at Assiniboine Hospital in Brandon have been discussed. The Brandon club of the Associated Canadian Travellers may share in the cost of building and equipping the new unit. Now three wards containing 60 beds are being used as general hospital sections for long-term patients. Eventually, all or nearly all the beds in the hospital will be used for this purpose.

Saskatchewan

Architects Webster and Forrester of Saskatoon are preparing plans for a new $2,000,000 addition to Holy Family Hospital in Prince Albert. The addition, if it is built, will provide facilities for 150 beds and a service area that will include an x-ray room, operating room, laboratory, pharmacy and central dressing room. It will be built to the east of the present hospital.

Construction of an extension to Providence Hospital in Moose Jaw will begin later this year. Included in the addition will be an operating suite and recovery room, a 20-bed obstetrical unit, a 24-bed nursery, an emergency department, a central supply room, a dietary department and cafeteria, and a 15-20 bed intensive care unit. Plans are being prepared by Wendell Marvin, of Storey and Marvin, Regina.

About 800 people had a chance to tour the new $300,000 Kerrobert Union Hospital in Kerrobert about a month before its official opening on Hospital Day in May. The 30-bed hospital is a single storey structure and is fully modern. The old hospital is being renovated and will be used as a nurses' home.

A fine new $30,000 health centre has been opened in Southey. On the main floor is a doctor's office, x-ray room, examination room, recovery room, dark room, optometrist's office, emergency treatment room, two nurses' offices and storage rooms. There is a kitchen in the basement.

The new $300,000 laboratory at the Regina General Hospital, Regina, is now in operation. The largest of the rooms into which the laboratory is divided is occupied by the biochemistry department. Smaller rooms along one side are for more specialized functions. Among the new equipment (most equipment was transferred from the old laboratory) are a unit for storing bones and blood vessels, a high speed centrifuge and a walk-in incubator. The laboratory also contains a large room which will be used as a pathology library and lecture room.

Today, less than a year after it was formed, the Northwest Regional Hospital Council boasts 19 member hospitals. In the council, which acts as consultant to its hospitals, are two representatives from the governing bodies of each of its members. They come from Cut Knife, Goodsoil, Hafford, Edam, Lashburn, Loon Lake, Maidstone, Meadow Lake, Neilburg, North Battleford, Paradise Hill, Rabbit Lake, Turtleford, Macklin, St. Walburg, Unity, Wilkie, Kerrobert and Kindersley.

The Saskatoon City Hospital in Saskatoon has celebrated its golden anniversary this year. To mark the occasion they have issued a booklet which gives a picture of what goes on at the present hospital, some indication of the past and a glimpse at the future. There was also a 50th anniversary program of special events from April 26 to May 7. Included in the special program was the nurses' graduation, conducted tours of the hospital, a meeting of the nurses' alumnae association and a special Jubilee Refresher course.

Alberta

Architects Aberdeen and Groves of Edmonton are preparing plans for a proposed 100-bed addition to the Good Samaritan Hospital in Edmonton. Construction costs are estimated at $500,000.

The Holy Cross Hospital in Calgary will have an addition of 60-80 beds. A floor will be added to a wing of the structure which was built in 1926. The present administration area will be renovated and there will be new laundry facilities.

Construction of a new 700-bed provincial mental hospital in Calgary is to begin this fall.

When interested citizens were invited to an open house at St. Mary's Hospital in Camrose recently, they had an opportunity of seeing many of the new additions to the hospital. One of the most noteworthy of these is the recovery room where post-operative patients can be watched carefully. Other features are the orthopaedic operating room, and a powerful new x-ray machine.

A dental operating room has been opened at the Calgary General Hospital in Calgary. The up-to-date department has four beds reserved for dental surgery patients. It offers out-patient service, in-patient service (people admitted to the hospital for 24-48 hours) and emergency service which is looked after by the dentist who is on call. The incumbent dentist takes over at 8 a.m. Friday and remains until 8 a.m. the following Friday. A call list has been arranged by about 40 dentists who are on staff.

British Columbia

Prince George and District Hospital's new $250,000 nurses' residence in Prince George has been officially opened. The residence, which will accommodate 54 nurses, stands beside the $2,000,000 hospital which is to be completed this fall.

The Creston Kiwanis Club will sponsor the construction of a health centre for Creston. The building will cost an estimated $22,000.

The North and West Vancouver Hospital Society has suggested that plans for the Lion's Gate Hospital be expanded by two floors. When completed in 1960 the hospital was to have had 283 beds, but the medical staff believes that more beds will be needed by the end of that year. Expansion of the initial unit would be economical and would mean less noise when the building is finally expanded to its ultimate capacity of 600 beds. Because the winning tender for the hospital was lower than expected, funds for the addition are available.

The Shuswap Lake General Hospital in Salmon Arm is to be completed this fall. The two-storey reinforced concrete building, which contains 50 beds, cost approximately $697,582. It replaces the old Salmon Arm General Hospital. ■

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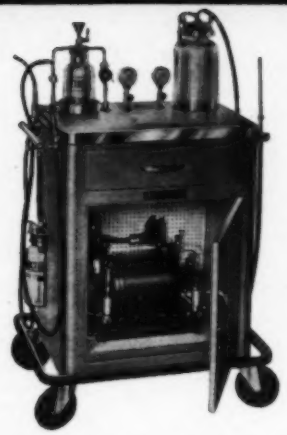

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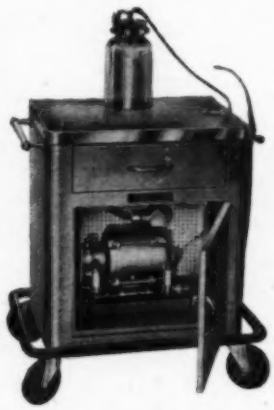
Now equipped with 32-ounce suction bottle for the exclusive use of the anesthetist in addition to the regular 1-gallon suction bottle and 32-ounce ether bottle.



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Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

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Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. Tompkins Model for suction only, Cat. No. 100-15 (not illustrated) is equipped with two 32-ounce suction bottles and no ether bottle.

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With the Auxiliaries

White Cross Guild Institute

The first White Cross Guild Institute at the Winnipeg General Hospital was held on April 22, 1959. The aim of this institute was to provide the ladies' auxiliary with an x-ray view of the hospital's operations.

The program began with an introduction by the president of the Guild. Dr. L. O. Bradley, the administrator of the Winnipeg General, followed with a description of the objectives, organization and ownership of the hospital. He said that his motives in bringing members together for the institute were more selfish than theirs in serving the hospital. It is a bit like the training of a professional person, he added. When you learn the whys and wherefores, there is personal involvement, interest and participation—and understanding brings acceptance of responsibility.

Financial operation and the hospital plan were next. They were discussed by the controller who described operating costs and particularly emphasized the problem of capital funds. The medical staff—who they are and what they do—was a subject outlined by the chairman of the medical staff.

An over-all look at the patients was then presented by the administrator. The various services to the patient—whether in- or out-patient—were discussed by the assistant administrator, Peter E. Swerhone.

Each hospital department head then spent three minutes describing the operation of his or her own department. For example, Judy Bennett, dietitian, enlivened the meeting with a description of ordering supplies and providing meals for patients and staff. This means a daily ration of 200 gallons of soup, 1,000 pork chops, 10 bags of potatoes, 620 quarts of milk, and 425 loaves of bread. "I pray for one satisfied customer and the strength to contend with 999 others," she said.

Taking Miss Bennett at her word, the meeting adjourned for lunch. This gave the department heads a chance to mingle with the group. After lunch the president of the board of trustees talked about the rôle and functions of the board. The final subject on the program was the future plans of the hospital. This was followed by a very lively, very interesting question and answer period.

Throughout, visual aids (blackboards, posters and charts) were used to advantage—and the meeting was very successful. Over 125 women came. In fact, the meeting is now to be an annual affair. For not only was the day valuable to the experienced members, but it also was responsible for presenting a clearer picture of the hospital to the new White Cross Guild volunteers.—*Peter R. Carruthers, Winnipeg General Hospital.*

New officers for the National Council of Hospital Auxiliaries of Canada, Inc. are: Back row: (l. to r.) first vice-presidents—Mrs. A. W. Hardy, Edmonton, Alta.; Christine Macleod, Winnipeg, Man.; Mrs. W. C. King, Estevan, Sask.; and treasurer—Mrs. John Kershman, Montreal, Que. Front row: (l. to r.) first vice-president—Mona Prentice, Montreal, Que.; Mrs. J. C. MacDougall, Montreal, who was re-elected president; and first vice-presidents—Mrs. J. D. Good, London, Ont.; and Mrs. A. M. Hunter, Halifax, N.S. Absent was the vice-president from B.C., Mrs. Atkinson.

Anniversary Tea

With pride, admiration and gratitude, the auxiliary of the Royal Alexandra Hospital, Edmonton, Alta., paid tribute to the far-sighted women who began the auxiliary in 1899. At the same time, the ladies said thank you to the doctors, nurses, and citizens for their recognition and support. The occasion was an anniversary tea, held in the new cafeteria of the hospital. In the centre of the tea table was a three-tiered birthday cake flanked by flickering white tapers. Mrs. D. A. Turner, an active auxiliary member for 26 years, had the honour of cutting the cake.

Presiding at the table were auxiliary presidents from the different hospitals in the city. There were also about 400 guests who were shown through the building housing cafeteria, auditorium, board and committee rooms and interns' quarters. Everyone enjoyed the party.

At the moment, the auxiliary has 50 members who have helped raise funds through bridges, fashion shows, dances, and so on. With these funds the ladies have been able to supply many pieces of equipment for the hospital. They have awarded scholarships and prizes, provided comforts for chronically ill and financially unfortunate patients, donated clothing and play therapy materials to the children's ward, and completed layettes for needy mothers. And, perhaps most important of all, the members make personal visits to many of the patients, brightening spirits with their warm and friendly smiles.

Okon Club

Because of the efforts of the women's auxiliary at the Colonel Belcher Hospital, Calgary, Alta., the Okon room there is a bright and cheery place. Here they operate a club where patients may entertain their families, chat with friends, or just sit and read. Six nights a week two women volunteers take sandwiches, cake and coffee to the club room where it is sold (at a very low price) to

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With the Auxiliaries

(concluded from page 62)

the patients. Any profits go into the club fund.

Besides running the Okon club, the ladies co-operate with the Red Cross, operate a library in the hospital, and take elderly patients to the recreation room where they can have fun square dancing—in their wheelchairs.

The Old and the New

There was a sharp contrast in styles when the ladies of the Royal Inland Hospital in Kamloops, B.C., held a spring fashion show. The auxiliary has been operating for 60 years, and so members who assisted with the show wore costumes that would have been popular with their organization's founders.

The models themselves delighted the audience as they displayed the newest styles. Particularly attractive were the bright colours of spring — pumpkin, ginger, and coral.

Christmas in the Spring

A gift tree, its limbs bedecked with presents for children, was the centre of attraction when the evening auxiliary of the Grace Hospital in Windsor, Ont., held its annual gift shop tea. The price of admission was a gift for the tree.

The $750 bursary which is presented annually to a graduate of the hospital's school of nursing, to help her take further training as an instructor, is maintained through the proceeds gained from this tea and from the gift shop which the auxiliary operates at the hospital. In addition to the gifts on the tree, the auxiliary took in $243.62 at the tea. It was a pleasant afternoon for guests and auxiliary members alike.

An Auxiliary Reports

The women's auxiliary of the South Peel Hospital, Cooksville, Ont., boasts a membership of 2,221 devoted women. The auxiliary is divided into 27 groups in South Peel. Each group has an area convenor, co-convenor, and street captains. All the groups sponsor their own money-making efforts, and take an active part in all auxiliary projects.

During the three years since its formation, the goal of the auxiliary has been to supply the new hospital completely with linen. This has been done. Now the auxiliary is responsible for the upkeep and renewal of all linen needed in the hospital.

Last summer a very successful car draw netted the ladies well over $12,000. Since the opening of the hospital in May 1958 the auxiliary gift shop has been very profitable. And at the last annual meeting, the sum of $5,000 was donated to the hospital's board of directors.

This year, on the afternoon of May 3, the auxiliary entertained the directors, hospital executives, doctors and their wives at a tea in honour of South Peel Hospital's first birthday.

Gift and Coffee Shop Opens

Made festive by huge bouquets of flowers, the new Gift and Coffee Shop at Hôpital Youville in Noranda, Que., was opened. More than 150 visitors were received at the opening—and they were pleased with what they saw. In the attractive room is a gift counter, a coffee bar and tables and chairs. Now hospital visitors can purchase gifts for their relatives and friends inside the hospital where the money can help the auxiliary carry on its good works. They can also enjoy a cup of coffee there, although the coffee bar has been set up primarily for the convenience of hospital staff and patients.

It's All for Sudbury Memorial

There is a great deal of activity within the units of the Sudbury Memorial Hospital's auxiliary in Sudbury, Ont. The ladies of the Coniston unit held a very successful tea and bake sale this spring. Bunnies and Easter eggs decorated the tea table. The members crowned the occasion with an hilarious April Fool Fashion Show—with the models the direct opposites of those who charm the audiences in most spring fashion displays.

An auction sale of new or nearly new articles was held by the members of the Lockerby unit. This also was a success—a very easy way of raising much-needed funds. After the sale, everyone enjoyed a cup of coffee and a friendly chat.

A woman's tears are one of the strongest natural antiseptics known to science. Diluted thousands of times they will still kill scores of different kinds of microbes. Tears are thus one of the strongest means of protection against infection.—*English Digest.*

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INFANT FORMULA MILKS

Food Preservation by Irradiation

M. Louise Smith,
Winnipeg, Man.

FOOD preservation by irradiation has undergone intensive study and experimentation during the last 12 years. It will soon be a recognized method of preserving food, along with heat processing, dehydrating, freezing, and other chemical methods. The destruction of micro-organisms by ionizing radiations has been known for many years and with the expansion of the nuclear program, more ionizing radiations have become available for experimentation with food.

Types and Sources of Radiation

Of the many types of ionization rays produced, x-rays, gamma rays and cathode rays are considered to be the most suitable for food sterilization. Cathode rays are artificially accelerated electrons produced from generators, whereas x-rays are electro-magnetic radiations produced when cathode rays come in contact with a target. Gamma rays resemble x-rays of short wave length and are emitted from naturally occurring and artificial radioactive elements.

Generating equipment for the production of radiations include the Van der Graaf accelerator which produces an uninterrupted beam of electrons, the resonant transformer which is essentially the same as x-ray equipment without the target, and an installation which produces intermittent bursts of electrons under great velocity. Of the waste radiation being tested from atomic energy plants, those radiations produced from used reactor rods during the cooling period, are the most satisfactory.

How Food is Sterilized

In cold sterilization, radiant energy is introduced into the food to destroy micro-organisms. This destruction takes place when an electron directly hits bacteria or induces radiation in the media by stirring up the molecules, which become radioactive and cause further destruction. This destruction of micro-organisms is accomplished in a very short time with a rise in temperature of no more than 5°F. In comparison to this, normal heat sterilization is produced with high temperatures and a very long cooking period. During heat processing most foods undergo extensive changes in texture, appearance, and flavour; and in some cases are greatly overcooked. With this new process it is expected that foods may be sterilized in the uncooked or partially cooked state and stored at room temperature or with very little refrigeration, for long periods of time. Radiation sterilization also has some restrictions, as undesirable side effects are evident in many of the foods undergoing experimental study.

Safety of Radiations

In experimental work on elemental food constituents which underwent irradiation, there was found to be no induced radioactivity. This is not sufficient evidence for the assumption that none exists. To meet the requirements of the United States Food and Drug Administration, an intensive program has been started, including feeding experiments on rats, mice, dogs and some testing has been done with human beings. Lehman and co-workers[5] point out the importance of studies being carried out with stress groups to determine the effect of radiation on impaired bodies, *e.g.*, persons with liver disease or other malfunction.

Rat feeding experiments[6] with irradiated ground meat, through a life span of two years, showed small decreases in growth and some decrease in size of litters. This last result was considered to be due to the vitamin E loss during irradiation of the food. The slight loss in weight was attributed to a slight decrease in the quality of the food by irradiation. In another rat experiment[1], the possibility of cancer from eating irradiated food was studied. No evidence of cancer was revealed in the three generations of animals tested.

Human being feeding experiments have been carried out since 1954 at the Army Nutrition Center at Fitzsimmons Hospital in Denver. Nine conscientious objectors, as subjects, were fed diets varying in quantity of irradiated food in two 15-day regimes. In the first study, 35 per cent of the food consumed was irradiated and in the following two studies the irradiated food included was 65 per cent and 80 per cent respectively. Recent reports indicated that similar studies with 100 per cent irradiated diets have been carried out with no apparent ill effects from the food consumed.

Radiation levels for Sterilization

Dose levels required for sterilization are dependent on the type of organisms present, the number of organisms present, as well as the chemical composition of the food. Bacterial spores as in conventional heat processing were found to be the most resistant to treatment, and study showed[8] that the dose level necessary to kill spores of *Clostridium botulinum* was 2 million roentgens in a concentration of 3500 per milliliter. The medium in which the spores were suspended, was found to have a direct bearing on the dose level. It has also been indicated that more energy is required to inactivate enzymes than to destroy food spoilage organisms. The more concentrated the enzymes the more resistant to irradiation they become. The possibility of destroying enzymes by blanching, before irradiation is being considered. The approximate dose necessary to de-activate enzymes in food is about 10 million rep. (roentgen equivalent physical), whereas the approximate dose for food sterilization is about 2 million rep.

Effect on flavour, colour and texture

Undesirable side reactions are often evident in irradiated food. These include flavour, colour and texture changes and are often noticed in foods treated with doses less than necessary for sterilization. Experimental study would indicate that the reactions necessary for flavour, colour and texture changes are also the same chemical reactions involving nutrients.

Some reduction in these side reactions has been accomplished by

(continued on page 68)

The author is assistant professor, School of Home Economics, University of Manitoba.

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1. Adams, Ralph, M. D. : Med. Times, 86:1119-1127 (Sept.) 1958.

Initial clinical studies on Vi-DRAPE Film were conducted by Carl Walter, M.D., Peter Bent Brigham Hospital, Boston.

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(continued from page 66)

irradiating in the frozen state, irradiating under vacuum and under inert gases, and by the addition of free radical acceptors. Freezing decreases the diffusion rate of the free radicals and makes them unavailable to cause these changes. It has been found that the elimination of oxygen reduces side reactions in some foods and this can be accomplished by irradiating under vacuum or in the presence of inert gases such as nitrogen. However, higher doses of irradiation are necessary to kill the bacteria, than in a normal atmosphere.

Radiations produce free radicals in the solvent which react with flavour molecules in the food. It is anticipated that by adding good free radical acceptors the flavour molecules, or other components, will be protected and that the radiation-induced free radicals will react with the free radical acceptors. In food materials, there are many components present that can react with the free radicals. Among these are flavour components which produce oxidized off-flavours when irradiated.

For a free radical acceptor to be highly acceptable it has to be effective in low concentrations, nontoxic and must mix thoroughly with the food being treated. Elimination of some off-flavours in food has been accomplished by the addition of ascorbic acid and its derivatives. These compounds act as free radical acceptors and come within the regulations of the Federal Food and Drug Administration.

In experimental studies on vegetables and on some fish products, the dose required for sterilization was determined and organoleptic studies were carried out. The foods were packed in air, in nitrogen, in a vacuum, and some were irradiated in the frozen state. It was found that asparagus, broccoli, green beans, sweet potatoes, spinach and cod fish cakes required doses of 1.5×10^6 rep for sterility and that the sterile dose for halibut was 2.0×10^6 rep.

The asparagus showed significant flavour changes when the radiation-treated products were vacuum packed, frozen, vacuum-packed and frozen, or packed in nitrogen. Broccoli showed significant flavour changes when irradiated in air pack, in a vacuum or in a nitrogen atmosphere, but had no flavour changes when irradiated in the frozen state. Brussels sprouts, green beans, spinach and sweet potatoes showed significant flavour change when irradiated at room temperature; cauliflower and lima beans showed significant changes under all conditions. The cod fish cakes showed no significant difference from the control whether irradiated in air, vacuum or frozen. However, the vacuum-packed product received the highest score. Halibut steaks showed no changes when irradiated.

Flavour changes of an oxidized nature were found in milk at very low irradiation doses (100,000 rep) which were decidedly below the level necessary to sterilize milk. Beef seemed to be more sensitive to irradiation than veal or pork. Ground beef was shown to be acceptable after ten days of storage at 38°F with doses of 50,000 to 100,000 rep. This dose, of course, was not a sterilization dose but rather a small dose capable of prolonging the shelf storage life of the beef. Beef exposed to 1.0 million rep revealed off-odours but no taste difference when 1 per cent sodium ascorbate was added as a free radical acceptor.

Colour changes were noted in asparagus, broccoli, cauliflower and peas which underwent irradiation of 2.6 rep gamma radiation from a Co_{60} source. The asparagus and peas were slightly darker green in colour and lost colour after one and three months' storage, respectively. Broccoli and brussels sprouts had a slightly brownish colour after treatment, and became considerably darker after three months storage. The cauliflower took on a grayish colour with irradiation and became somewhat darkened on storage. The texture in all these vegetables was slightly softer. Irradiated strawberries, cherries and melon, treated with irradiations of 3×10^6 rep, showed colour and texture changes. The strawberries and cherries lost some of their red colour and the cherries turned brown. All these fruits had a softer, mushier texture not found in the fresh fruits.

Colour changes were observed with irradiated beef and salmon. The hematin pigments in the irradiated fresh beef were a brighter red because of increased oxymyoglobin, and in the salmon the carotenoid pigment was destroyed.

Effect on Nutrients

Considerable experimental work has been done with food nutrients to observe the changes which they undergo with irradiation. An increase in peroxidase value was noted[3] in butterfat along with a reduction in keeping quality after irradiation. This was thought to be due to the destruction of the tocopherols in the fat. Bleaching was evident in the fat and increased with an increase in dose. Addition of antioxidants such as thyl gallate, before irradiation is considered as a possible means of lengthening storage life.

Proteins in meat[3] composed of sulfur containing peptides decomposed to hydrogen sulfide and mercaptans on irradiation, producing off-flavours and odours. Certain spices, added to the meat helped mask the undesirable off-flavours.

Vitamin A, vitamin E and ascorbic acid underwent considerable destruction[4] when fresh milk, evaporated milk, cream, cheese, butter and margarine were subjected to sterilizing doses. On the other hand, the riboflavins and carotenoids were found to be reasonably stable.

In studying the effect of x-rays on niacin in solution[7] it was observed that there was more destruction in a dilute solution than in a concentrated solution, suggesting that destruction of niacin was by indirect irradiation rather than by direct "hits". It was also noted that niacin irradiated in solution with ascorbic acid underwent greater destruction than when irradiated alone. In actual experiments with irradiated turkey[8], niacin was found to undergo the least destruction, thiamine loss was up to 90 per cent and riboflavin up to 17 per cent; the loss being in relation to the size of dose. Irradiation was found to have much the same effect on loss of niacin, thiamine and riboflavin as is observed with heat treatment.

It is evident from the experimental work that has been carried out that no over-all dose can be predicted for "classes" of foods. Each food requires different doses under different conditions to produce minimum colour, flavour and texture changes in it.

Other uses for radiation

Other successful applications of irradiations are being made with foods, using smaller doses than required for sterilization. Potatoes and onions exposed to gamma rays, showed a marked decrease in sprouting. Doses of 50,000 rep or less controlled insect infestation in grain with no effect on baking quality of the flour, or flavour of

(continued on page 92)

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Notes on Federal Grants

Construction

McKellar General Hospital in Fort William, Ont., is to receive $168,786 to help in providing additional accommodation for 148 nurses, a four-bed infirmary and teaching facilities.

A 12-bed addition to the Hotel Dieu Hospital in St. Catharines, Ont., along with accommodation for nine nurses has been granted $16,976 to aid in construction.

Out-patient services, teaching facilities and more accommodation —for 174 epileptic patients are to be added to the Hôtel-Dieu du Sacré Coeur de Jésus, Quebec, Que. The hospital, a specialized centre for the treatment of epileptics, will receive a $422,140 grant from the federal government.

A new nurses' residence for the Hôpital Notre-Dame de Sainte-Croix, Mont Laurier, Que., will be helped by a $24,750 grant. To be built next to the hospital, the residence is to have accommodation for 33 nurses.

Some $28,599 will assist Lloydminster Hospital, Lloydminster, Sask., to build a new nurses' residence. Along with rooms for 49 nurses, the new building will house kitchen, recreation, the necessary toilet and bathroom and utility and storage facilities.

A new hospital in Burlington, Ont.,—the Joseph Brant Memorial Hospital—is slated to have a capacity for 204 patients, 46 bassinets and an out-patient service, as well as medical, surgical and obstetrical services, and accommodation for two interns. This project has been granted $521,326.

The Milton District Hospital, providing 58 patient beds and 18 bassinets and an out-patient service will be assisted by a grant of $153,686 for construction costs. The new hospital, of steel and masonry, should be completed by September this year.

The Herbert-Morse Union Hospital at Herbert, Sask., will provide six additional beds, six more bassinets and out-patient treatment areas with their grant of $13,417. A laboratory and x-ray department is also planned.

About $24,072 has been awarded to Big River Union Hospital, Big River, Sask., for assistance in building a new addition which will house 11 beds and a four-bassinet nursery.

A new hospital for mental patients is to be constructed at L'Annonciation, Quebec, with the aid of a $1,529,985 grant. L'Hôpital des Laurentides, as it is called, will have 786 beds, and stands as part of an over-all provincial program for the extension of mental health services. It will care for and treat chronic mental cases.

The Barrie Memorial Hospital in Ormstown, Que., is to have a new 14-bed nurses' residence. A $10,500 grant will help pay the cost.

An amount of $191,038 goes to Grace Hospital, Vancouver, to help cover construction costs of a new wing and renovations in the present building. The boiler house and heating equipment is to be remodelled, and a new wing is to add 43 beds and 32 bassinets.

Victoria Public Hospital, Fredericton, N.B., has been granted $132,166 for constructing west and north-east wing additions, to add 80 more beds. Existing facilities, to improve the hospital's accommodation and services, will also be renovated.

A grant of $11,055 will assist in re-building a wing of L'Hôpital Richelieu, Sorel, Que. Both a nursery and paediatric beds are to be housed in the wing. Renovation work, also scheduled at the hospital, will increase the facilities by ten active treatment beds and 21 bassinets.

A new three-storey residence at the Ottawa General Hospital, Ottawa, Ont., will give space for 54 interns and will be helped by a $40,500 federal allotment. The present interns' residence will be converted into apartments for married interns.

Facilities at the Hôtel-Dieu de L'Assomption, Moncton, N.B., are to be expanded with the assistance of a $3,059 grant.

Construction of a new health centre at Smithers, B.C., will be aided by a $5,133 grant. The new centre, operated by the village, is to replace present facilities now located in the provincial government building in Smithers. Services will be available not only to Smithers' residents, but to those of Telkwa and Houston, nearby towns and unorganized settlements, as well.

Diagnostic and Research

Some $82,115 goes to St-François d'Assise Hospital, Quebec, Que., for buying new radiological equipment.

The University of Toronto, Ont., has been granted $9,525 to assist with research on the pulmonary effects of iron and silica dusts and fumes, a program under the direction of Dr. A. M. Fisher, associate professor, Department of Physiological Hygiene at the university.

To aid in the study of anoxia, a condition caused by an inadequate supply of oxygen in unborn and new born babies, Queen's University in Kingston, Ont., will receive $10,960. This project, conducted by Dr. J. D. Hatcher, associate professor, Department of Physiology at Queen's, is hoped to lead to a greater understanding of this cause of mortality and morbidity surrounding childbirth.

A grant of $7,204 will go to the Research Institute of the Hospital for Sick Children, Toronto, Ont., where Dr. Donald M. McLean, virologist, will investigate viruses as causative agents in diarrhea of infants in an effort to establish methods of prevention of subsequent outbreaks of virus-induced infantile diarrhea.

The University of Toronto also receives $5,210 to assist in the study of the effect of antihistamines on respiration during both normal and toxaemic pregnancies in an effort to discover a method of reducing maternal deaths due to pulmonary complications following the use of anaesthetic. The study will be conducted at the Toronto General Hospital under Dr. D. E. Cannell, professor and head of the Department of Obstetrics and Gynaecology.

A disease survey among Canadian Eskimos is to be helped by $3,600 from the government. Dr. J. M. Lederman, professor and head of the Department of Pathology, and Dr. J. S. Hildes, D.R.B., Arctic Medical Research Unit, Department of Physiology and Medical Research at the University of Manitoba, will direct the project to ascertain the incidence of specific diseases in Eskimos, particularly arteriosclerosis and cancer.

A second project, receiving $3,015

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Federal Grants

(concluded from page 70)

from a grant, will try to determine the antibodies present in the blood of Eskimos of different regions; thus helping in determining the types of infectious diseases occurring in northern regions. This program will be under Dr. J. C. Wilt, professor and head of the Department of Bacteriology and Immunology, and Dr. Hildes, of the University of Manitoba.

New radiological equipment will be purchased for Hôtel-Dieu, Montreal, Que., with part of their grant of $92,470. This equipment combines x-ray apparatus with moving picture cameras and television.

A long-range study of high blood pressure in man—its causes, its natural progress and the probable result—under the direction of Dr. K. A. Evelyn, professor of medicine, University of British Columbia, will be helped by a grant of $9,470. The University of B.C. also will receive a second grant—of $5,329—for its study of connective tissue metabolism and chemical compounds which are known to have an effect on connective tissue disorders, including rheumatoid disease. This project, under Dr. H. E. Taylor, professor and head of the Department of Pathology at the university, is expected to lead to better therapeutic approaches.

Additional x-ray equipment for the 225-bed Hôpital Sainte-Croix, Drummondville, Que., will be bought with a $58,187 grant.

The University of Saskatchewan also has been awarded a grant for research. Some $4,900 will help finance research into possible causes of mental retardation, a project to be conducted at the University Hospital, Saskatoon, by Dr. J. W. Gerrard, professor of paediatrics and Dr. A. M. Marko, research associate, with the Department of Paediatrics. They will study the urinary amino acids, indoles and sugars in children with mental retardation.

In Val d'Or, Que., Hôpital Saint-Sauveur has been granted $22,016 to go towards the purchase of new x-ray equipment to help handle the increasing volume of work which comes to the hospital from Malartic, some Indian reserves and a number of mining and lumbering communities near Val d'Or.

Hôpital Saint-Michel, Buckingham, Que., gets $7,428 for laboratory equipment.

Mental Health

Grants totalling $34,668 will help the University of British Columbia in research projects on schizophrenia. Two projects, both directed by Dr. W. C. Gibson, professor of neurological research there, will probe the behaviour patterns of animals injected with urine extracts of normals and schizophrenics, and an attempt to determine chemical tests for use as clinical aids in the diagnosis and treatment of schizophrenia.

Public Health

Some $20,000 will help finance an air ambulance service for patients from distant and isolated parts of Quebec, such as the North Shore, Anticosti Island, the Magdalen Islands.

Another grant of $7,396 will be used for purchasing blood transfusion equipment on behalf of Hôpital St-Luc, Montreal, Que. This equipment will aid blood grouping, blood typing and transfusion services.

Allotted to assist the Epileptic Division of the B.C. Society for Crippled Children in a program for establishing an information centre for epileptic patients is $10,000. These services will be gradually developed to provide educational, rehabilitative, medical and social support to epileptics throughout British Columbia.

A treatment program for rheumatic fever patients will be established with the help of a $5,000 federal grant. Four health units, picked for their location and interest, will institute the new project. These are the Simon Fraser, Boundary, Upper Island and the South Okanagan units, which will provide penicillin to children and adolescents who meet certain medical standards. The program, it is hoped, will reduce cardiac complications from acute rheumatic fever.

Coming Conventions

June 21-25—Canadian Society of Laboratory Technologists, annual meeting and convention, Palliser Hotel, Calgary, Alta.

June 24-26—Comité des Hôpitaux du Québec, annual convention and commercial and scientific exhibition, Montreal Show Mart Inc., Montreal, Que.

July 12-17—American Association of Hospital Accountants, 17th annual Institute on Hospital Accounting and Finance, Indiana University, Bloomington, Ind., U.S.A.

July 20-24—Canadian Medical Association—British Medical Association, joint annual meeting, Edinburgh, Scotland.

July 27-31—First International Medical Conference on Mental Retardation, The Eastland Hotel, Portland, Me., U.S.A.

Aug. 2-4—Maritime Conference of the Catholic Hospital Association of Canada, annual meeting, Notre Dame d'Acadie College, Moncton, N.B.

Aug. 23-26—American College of Hospital Administrators, 25th annual meeting and convocation, Statler Hotel, New York City.

Aug. 24-27—American Hospital Association, annual convention, Coliseum, Statler Hotel, New York City, N.Y.

Sept. 6-12—World Confederation for Physical Therapy, 3rd international congress, Paris, France.

Sept. 8-12—Western Canada Institute, Royal Alexandra Hotel, Winnipeg, Manitoba.

Sept. 22-23—Catholic Hospital Conference of Alberta, 16th annual meeting, Corona Hotel, Edmonton, Alta.

Oct. 14-16—Saskatchewan Hospital Association, annual meeting and convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 17—Catholic Hospital Conference of Saskatchewan, annual meeting, Bessborough Hotel, Saskatoon, Sask.

Oct. 18-19—Catholic Hospital Conference of British Columbia, annual convention, Vancouver, B.C.

Oct. 20-23—British Columbia Hospitals' Association, annual convention, Hotel Vancouver, Vancouver, B.C.

Oct. 21-23—Conference on Cerebral Palsy, sponsored by the Cerebral Palsy Association of Quebec, Inc., 10th anniversary conference, Montreal, Que.

Oct. 26-28—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 27-29—Associated Hospitals of Alberta, annual convention, Jubilee Auditorium, Edmonton, Alta.

Oct. 29-30—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

Speaking without thinking is shooting without aiming.—*Eng. Dig.*

Montreal Milestone

(continued from page 52)

health matters without thinking of the Washington Service Bureau. The Bureau has in mind the ultimate goal of being consulted first on all matters relating to the hospital field, so that Congress heeds the hospital association's voice—an association that has only the public's welfare at heart.

Mr. Williamson's provocative revelations prompted spirited response from his listeners. Do Canadian hospitals, too, need to be more realistic in their relations with federal legislators? Lobbying in Ottawa had its champions and it was suggested that the first step toward firm, good relations with parliament was through strong and united provincial associations. All was not admiration for the American scheme, however. "Hospitals should not be political footballs" and, it was maintained, "Lobbying is not Canada's way of life."

Dr. J. Gilbert Turner reported on our present relations with the A.H.A. — good-will prevails. The A.H.A., Dr. Turner stated, is concerned about the loss of Canadian members and has proposed three new rulings which the C.H.A. assembly should consider. There is an agreement that the executive directors of each association work together (combined reporting); the House of Delegates of the A.H.A. is to be reorganized, reducing the number of Canadian seats to three; and the A.H.A. is prepared to recommend to its board that starting January 1, 1960, there be a further reduction of Canadian fees (to a maximum of 1/3 the U.S. rate, which means a decrease from $600 to $400).

Two reports from associate members of the C.H.A. rounded out the session. One from G. A. Wilkinson, representing the Canadian Society of Radiological Technicians, restated the Society's chief purpose—to raise the standards of training for radiological technicians. He urged support for the improvement of the technicians' education, and for the creation of a program for accrediting training schools. Such support is to the mutual advantage of both the C.H.A. and the C.S.R.T. in the interests of patient care.

Stanley Martin, as vice-president of the Canadian Council of Blue Cross Plans, described the still healthy nature of Blue Cross, since the coming of national hospital insurance. As a supplemental coverage plan it is well supported and still has an important function.

Toward Better Nursing

Nurses can do better. How and by what means they can provided the topics discussed by an able panel of those who should know. The panel chairman, Alice Girard, president of the Canadian Nurses' Association and director of nursing at l'Hôpital St-Luc, Montreal, introduced the speakers. Representing nursing service and its policies were Rev. Sister Mary Felicitas, chairman of the C.N.A.'s Committee on Nursing Service and director of nursing at St. Mary's Hospital in Montreal; and Ella Howard, chairman of the R.N.A.O. Committee on Nursing Service and director of nursing at New Mount Sinai Hospital, Toronto. Hazel Keeler, chairman, C.N.A. Committee on Nursing Education and director of the School of Nursing at the University of Saskatchewan, Saskatoon; and Helen Mussallem, director of the pilot project for the evaluation of schools of nursing in Canada, of the Canadian Nurses' Association, Ottawa, were the well qualified spokesmen for the education of nurses.

Rapid changes in medical practice have meant changes in hospitals and in nursing service, reminded Sr. M. Felicitas. But two things do not change—the patient's need and the nurse's giving, and these will always remain as the essence of service for the nurse. The C.N.A., she said, has recognized that the policy in nursing service is based on adequate nursing care, geared to changing conditions. These changes have meant that the nurses' duties have been reappraised and many have been reassigned to other departments and to nursing aides and assistants. How can this service be improved? It must always be patient-centred and be bolstered by sound administrative practices coupled with good nursing education. "Attitudes are caught, not taught," she stated, in speaking of how important it is that a close, interested and understanding relationship be fostered among administrators, nursing supervisors and students. The graduate R.N. should inspire the student. She stressed, too, the development of the team plan in nursing and how the nurses' training and abilities are used to best advantage in a system of decentralized authority, when each member feels useful and stimulated, all working together toward a common goal. This team method depends on combined efforts, organized by a competent leader. Sr. Felicitas ended with a plea that nurses should be informed and involved more in the planning of nursing services under hospital insurance schemes—since nurses have such a strategic rôle in carrying out the health plan.

Ella Howard drew the audience's attention to the pamphlet, "Purposes and Aims of Nursing Service", which defines the concepts and ethics of sound nursing service. Miss Howard emphasized particularly the *atmosphere* within which the service functions. This is all important and depends upon the philosophy pervading the institution. The worth of the worker (reflected in personnel policies); the place of the hospital in the community; and what is really meant by the "nursing care" which the patient receives—these should be clear to the administration, believed in and supported, before the hospital's atmosphere becomes positive. Miss Howard gave an imaginative illustration of nursing service as a giant wheel with the patient as the hub, nursing units as spokes and administration (particularly nursing administration) as the rim, giving organization and support to the spokes in helping them keep centred on the hub. She also endorsed the policy of "getting nurses back to nursing" and leaving the linen to the laundry and the formulae to the dietary department, as being outside nursing service.

"Criticism", said Hazel Keeler in turning the discussion to the education of nurses, "leveled at the nurses' education as being too technical with no bedside nursing, cannot be ignored." But the problems and challenges involved in nurses' education today need to be understood. Nurses are the product of the times, moulded by social forces, the medical sciences and attitudes to health. Knowledge has advanced, theory changed — old standards and patterns are no longer realistic. Today the nurse is in a middle "technical ground". There is a gap, realized by the C.N.A. and nursing educators, between what nurses are prepared for and what is expected of them; and Miss Keeler went on to lay emphasis on the administrative, supervisory and teaching demands made on the newly graduated nurse. Here is a field where it is necessary to develop more and better educational programs so that nurses can prepare themselves to ac-

(concluded on page 80)

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Montreal Milestone

(concluded from page 76)

cept the new responsibilities expected of them.

Helen Mussallem, the final speaker on the panel, was convinced that if better nursing care was to be given, the nurses' preparation must be improved. Here is where a scheme for accreditation of nursing schools comes in. She reported on the work done by the pilot study on such a program, which was carried out in 25 selected schools across Canada. A report of the study's findings will be available when it is published; then nurses will have to decide if they are ready for national accreditation and if it will be feasible.

What's Coming

Wednesday morning saw an interesting trio of speakers giving those assembled peeks into the future of hospital design, hospital services, and financing capital costs.

Dr. J. Gilbert Turner of the Royal Victoria Hospital, Montreal, speaking on capital costs, warned the assembly that in this matter there is no magic formula. The emphasis must be put on local personalized service — not on remote control. Don't defer maintenance and renovations, but remember the principle that hospitals should be in good repair, as hospitals are expected to keep pace with medical progress—a progress that brings about obsolescence in equipment and buildings so quickly. Trends indicate that many new hospitals will be required. Sensible and sound financing to meet these new and increasing demands call for a co-ordinated effort. A planning group, heeding the realistic needs of the community, is necessary. Self government by hospitals, Dr. Turner went on, must be accepted and carries with it the acceptance of financial responsibilities locally. What percentage is expected from governments? The federal government seems happy to restrict its share to construction grants. There is too much publicity about the federal government paying half the costs of the insurance program, stated the speaker. Ottawa should change its publicity; the basis is *not* 50-50, and the federal government's share is only a contribution. The major responsibility seems to rest with the provincial governments, and how each province works out problems at the local level depends on the relations between the provincial and local authorities.

Dr. Turner went on to state forcefully his belief in the voluntary system—which means again that it is the local community which must be responsible for capital costs. The donation method is good, but is not a comprehensive system like a mill or tax rate. A decision between the two methods of financing should be made locally.

Dr. Turner suggested a provincial body whose sole purpose would be to sound out hospital construction needs and from these evolve a master plan for the province. He also suggested that research facilities should be aided by the federal government, as research was in the whole country's interest. Was it possible for a research hospital or research institute of hospital management to be established where the pros and cons of hospital administration might be studied? Here is the field of the future, he concluded, through which we can improve our ways.

"How old is new?" was the question posed by H. Gordon Hughes, chief of the Hospital Design Division, Department of National Health and Welfare, Ottawa. In trying to pinpoint the future trends in hospital design, Mr. Hughes analyzed the impressions formed by the people of the Design Division from the hundreds of blueprints that passed through their hands. He noted the advance in quality of these plans, more originality, and the evidence that allied planning had gone into them. The trends discovered? To mention just a few—more parking facilities, de-centralized nursing stations, more toilet space (needed because of the trend to early ambulation), increasing use of double corridors (especially in smaller hospitals), the changes for the better brought about by good artificial lighting and ventilation developments, and the beginnings of a trend to progressive care.

D. W. Ogilvie, Hospital Insurance Branch, Ontario Hospital Services Commission, completed Wednesday afternoon's panel by discussing the trends in utilization of hospital services. "Hospitals have never been so important in the life of our people," he claimed. Mr. Ogilvie then pointed out how three main forces — the changing pattern of patient care, the introduction of pre-payment systems, and the sociological changes within the community—have affected the trend to increased hospital use in the past few decades. The control of the services, of course, he said, rests with the doctors who must exercise carefully their professional judgment in deciding fitness. The bed ratio average needs adjusting and, he continued, we must be more realistic in locating beds where they are needed. We must remember, he cautioned, that as the ratio increases, so does the demand, because the doctors' criteria change according to bed availability.

He spoke also of the Ontario Commission's survey of beds and their use, and of the problems of long stay patients taking up active treatment beds. "It is obvious", he claimed, "that we need more homes for the aged and a system of public nursing homes". Mr. Ogilvie concluded with a challenging thought—"Is enough being done in the study and development of hospital-based home care plans?"

Keynote speaker for the convention was Dr. R. W. Ian Urquhart, chairman of the Ontario Hospital Services Commission, who addressed the assembly on the virtues and benefits of co-operation. Under the title "Double Harness", Dr. Urquhart illustrated the meaning of pulling together in a team by comparing the Department of National Health and Welfare and the provincial commissions to a tandem. The commissions together with the hospitals serve as the wheel team, carrying the load to a common destination. "Each must carry his fair share of the load by accepting his particular responsibilities, not expecting the other one to do it." He described the budget as the harness which links the hospitals to the commissions, and concluded by calling on the various teams of hospital groups which must always pull together to drive the hospital insurance plan to success. (See page 43).

Bonhommie at the Banquet

On Tuesday evening, at the association's banquet, due tribute was paid to many well-known men who have left their mark in the hospital field. Each living past-president of the C.H.A. was introduced by a brief personal history and tale of his achievement before being presented with a newly-designed past-president's pin. The Rev. Georges Verreault (president from 1937-39) of Montreal, Que.; Arthur J. Swanson (1945-49) of Toronto, Ont.; R. Fraser Armstrong (1949-51) of Kingston, Ont.; Angus C. McGugan, M.D. (1953-55) of Edmonton, Alta.; and J. Gilbert Turner, M.D. (1955-57) of Montreal,

Que., all received a welcome and applause for their contributions to the association's work.

George Bourke, president of the Sun Life Assurance Company of Canada, who was also a head table guest, spoke briefly of his company's pride in its long association with the C.H.A., and assured us that Sun Life will continue its interest in the association's work. Dr. Piercey, in announcing Murray Ross's resignation from the C.H.A. staff to become chief executive officer of the Associated Hospitals of Alberta, wished him well and thanked him for his eight years of service at C.H.A. headquarters. Dr. Porter then presented Mr. Ross with a gift brief case to take on his travels in Alberta.

The climax of the evening, of course, was the presentation of the George Findlay Stephens Memorial Award to Dr. A. C. McGugan of Edmonton. Dr. Piercey read out the citation which listed Dr. McGugan's accomplishments and service to the hospitals of Canada. (See *Canadian Hospital*, March, 1959, page 32.)

New Officers Elected

The C.H.A.'s new slate of officers, elected at this biennial meeting, are as follows: *immediate past-president* — Dr. D. F. W. Porter, Vallée Lourdes, N.B.; *president* — Stanley W. Martin, Toronto, Ont.; *first vice-president* — Chief Judge Nelles V. Buchanan, Edmonton, Alta.; *second vice-president*— Harvey E. Taylor, Port Alberni, B.C.; and *treasurer*—Dr. John E. Sharpe, Toronto, Ont. The *board of directors* now is composed of C. E. Barton, Regina, Sask.; J. E. Robinson, Winnipeg, Man.; Dr. Paul Bourgeois, Montreal, Que.; Sr. Catherine Gerard, Halifax, N.S.; Rev. J. B. Nearing, Sydney, N.S.; Rev. Father Hector Bertrand, Montreal, Que.; C. N. Weber, Kitchener, Ont.; and A. H. Westbury, Montreal, Que. *Honorary president* of the Association is the Hon. J. Waldo Monteith.

For resolutions adopted by the C.H.A. assembly see page 53.

Having passed the momentous Montreal milestone, the Canadian Hospital Association can look ahead now to the next mile. Maybe it will be covered even faster, even more energetically than the last. ■

Change of Address

The headquarters of the Blue Cross Commission of the American Hospital Association is now located in Room 620, 840 North Lake Shore Drive, Chicago 11, Ill.

Resolutions

(concluded from page 53)

pressing its sincere thanks and appreciation as follows:

1. To the president and associate secretary of the Sun Life Assurance Company of Canada for their attendance at, and participation in, this meeting; and to the officers of the company for their continued interest in the work of the association and their financial support of its program.

2. To the W. K. Kellogg Foundation for its substantial financial support of the educational programs sponsored by the association and for its continued interest in the development of future programs directed toward the improvement of hospital service in Canada.

3. To the Canadian Council of Blue Cross Plans for its continued interest and financial support of the work of the association.

4. To the Junior Chamber of Commerce of Montreal, and in particular to Miss Andrée Francoeur, the official translator, for greatly speeding the proceedings of the meeting through the provision of simultaneous translation services.

5. To the Hon. J. Waldo Monteith, Minister of National Health and Welfare, and the several members of his departmental staff for their participation in the program of the meeting and their expressed willingness and desire to maintain the closest liaison and most harmonious relationship with the association in dealing with mutual problems in the future.

6. To the Dominion Bureau of Statistics and its representatives at the meeting for their continued interest and help.

7. To the departments of provincial governments which have had representatives at this meeting, citing particularly (a) Donald M. Cox of British Columbia for his continuing enthusiasm, loyal support and regular attendance at meetings of the association, and (b) Dr. Ian Urquhart, chairman of the Ontario Hospital Services Commission, and commissioners D. W. Ogilvie and Dr. J. B. Neilson for their participation in our program and for their great interest in the work of the association.

8. To Dr. A. Lorne C. Gilday, Dr. G. Harvey Agnew, Chief Judge Nelles V. Buchanan, and George W. Bourke, president of the Sun Life Assurance Company of Canada, for their attendance at the association's dinner and their participation in the ceremonies of presentation of past-presidents' pins.

9. To the executive director, his assistants, and members of the headquarters staff for their interest and devotion to duty, not only during the meeting but throughout the year.

10. To the Canadian Nurses' Association and in particular to Alice Girard, its president, Sr. Mary Felicitas, Ella Howard, Hazel Keeler, and Helen Mussallem, for a most interesting and informative panel on nursing service and education and, further, we acknowledge the happy relationship and liaison maintained between the officers of the two organizations.

11. To the management and staff of the Queen Elizabeth Hotel for their excellent facilities for the meeting, having in mind the comments of the staff to the effect that at no previous meeting in their memory have the services provided been so effective, extensive and so efficiently provided.

12. To the Metropolitan Life Insurance Company for its contribution to improved hospital public relations by conducting an advertising program stressing the need for continued voluntary support of hospitals.

13. To the officers and directors of the association during the past year for their efforts and diligence in carrying out their duties on our behalf.

14. To the Canadian Medical Association for their continuing interest and for the attendance of their senior officers at this meeting, and to Doctors Van Wart and Kelly for their able assistance.

15. To the American Hospital Association, its president, Ray Amberg; its director, Dr. Edwin L. Crosby; and associate director, Kenneth Williamson, for their cordiality and continued friendship and for their attendance at and participation in our fifteenth biennial meeting.

Dr. Harvey Agnew

BE IT RESOLVED that we express our sincere sympathy to Dr. Agnew in the passing of Mrs. Agnew who was known and loved by so many of us.

American Hospital Association

WHEREAS the Canadian Hospital Association and the American Hospital Association have common objectives

AND WHEREAS it has been evident from personal approach of representatives of the American Hospital Association to the Canadian Hospital Association that they consider a closer relationship between the two associations desirable and can be of mutual advantage,

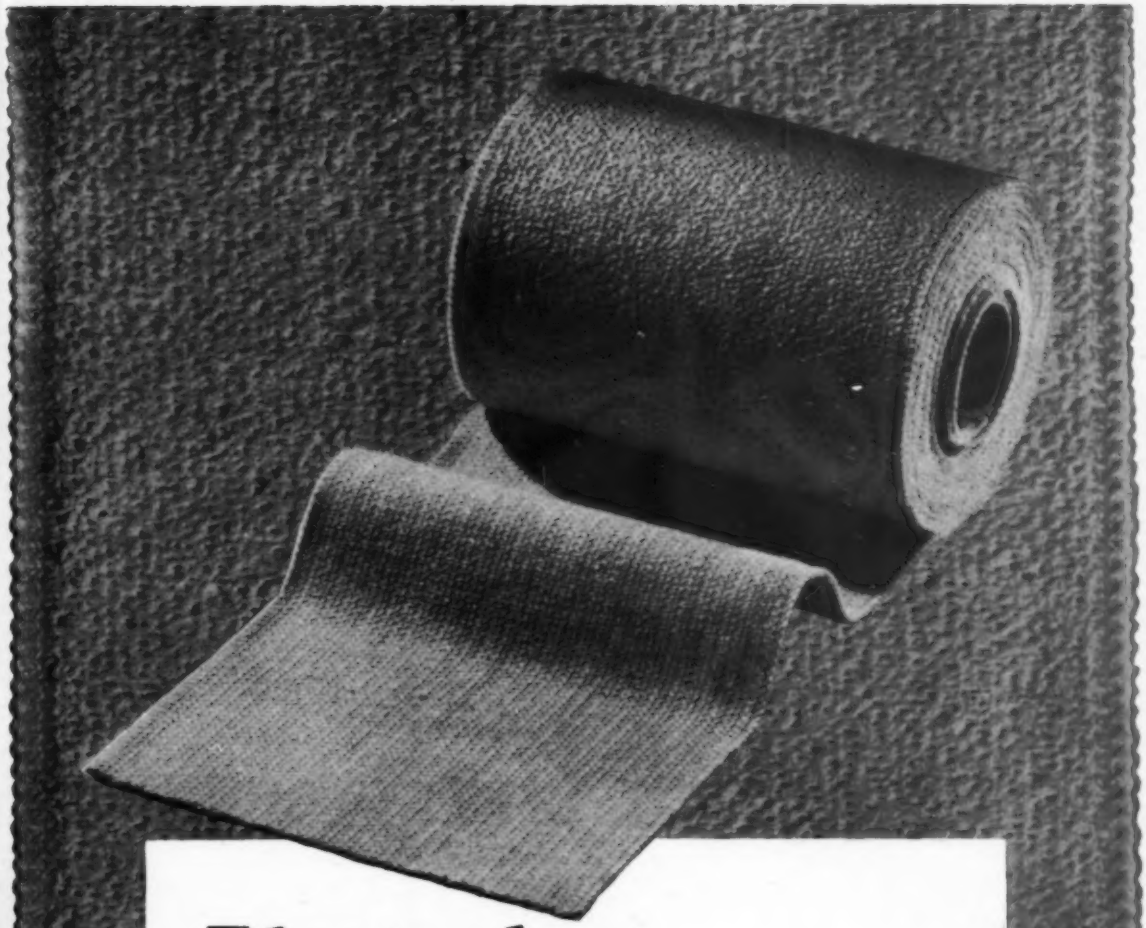
AND WHEREAS the American Hospital Association has defined certain principles which it considers worthy of consideration in bringing about a closer relationship between the two associations,

BE IT THEREFORE RESOLVED that the assembly approve of granting authority to the board of directors to develop an agreement between the two associations without any financial commitment to or by the Canadian Hospital Association to deal specifically with the following: (a) a plan for improved liaison between the executive staffs of the respective associations; (b) the determination of the members and method of selection of representatives from Canada to the house of delegates and the board of trustees of the American Hospital Association; (c) a plan for development of areas of mutual interest especially in the educational field, and by the free exchange of information between the two associations; and (d) the schedule of membership fees payable by Canadian hospitals to be at the rate of one-third of the fee payable by comparable hospitals in the United States with a minimal annual fee of $90. ■

Successful Pioneer

This month a four-day course for the Canadian Association of Radiological Technicians took place at Queen's University, Kingston, Ont. It dealt with the requirements of the new syllabus set up by the Canadian Society of Radiological Technicians in co-operation with the Canadian Association of Radiologists. It was conducted by a zealous and energetic woman, Sister M. deLellis, who is supervisor of the x-ray department and instructor of x-ray technicians at St. Joseph's Hospital, Saint John, N.B.

Sister deLellis was one of the first women in Canada to obtain a university degree in radiographic technology. Twenty-five years ago, when the hospital offered a one-year course in this subject, she was an instructor. Later this became a two-year course and Sister deLellis went to St. Louis for her degree which she obtained in 1948. She was also chosen as instructor for a refresher course in radiological technology at an international meeting of x-ray technicians held in Washington in 1957. Hers has been a life of faithful and devoted service.



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Progress Report
(continued from page 37)

surance program throws new emphasis on effective utilization. For instance, in placing no limits on hospital stay other than medical necessity, it brings to the fore the problem of long-term care. While there are a number of ways of tackling this problem, modern developments in the care of the chronically ill have illustrated that one of the most useful is gearing long-term care to rehabilitation. It would follow, therefore, that the more we emphasize good rehabilitation services, the more success we shall achieve. The federal legislation is designed to promote this, since it includes within shareable costs the provision of rehabilitation services on both an in-patient and out-patient basis.

On the subject of costs, I feel that here again we are still not entirely on firm ground with regard to the program's progress. Final calculations of federal payments for 1958-59 have not yet been made, and until they are, the picture will not be completely clear. Nevertheless, it can be said that the pattern of our monthly advances to provincial plans has been favourable. By and large, these have not exceeded prior estimates. This, in itself, is encouraging—if only preliminary—evidence of the plan's effective operation.

As far as the current fiscal year is concerned, you might be interested to know that our forecast of federal contributions to participating provinces is $160 million. This is a very substantial sum. When you consider that it will be matched by provincial outlays, you have a rough idea of the degree of assistance which Canadian hospitals will be receiving from public funds.

Federal contributions apply, of course, only to operating costs. They do not cover capital depreciation or debt. From briefs I have received from the Canadian Hospital Association, I realize that you are not altogether happy with the exclusion of these capital costs from the insurance program. I can understand your feeling. In fact, I will admit that as a chartered accountant I, myself, have been in the habit of regarding depreciation as a part of operating expenses. Why then has this not been done? There are a number of reasons which I would like to present for your consideration. I am going to speak frankly because I want you to have a clear understanding of the situation as we see it.

First, there is the present financial situation of the Dominion government. In the last few years, Canada has been faced with a slow-up in economic activity. Fortunately, we are pulling out of it, but the recession has imposed a heavy burden on the federal treasury. Our deficit for 1958-59 was over $600 million; and we are expecting outlays to exceed revenues by nearly $400 million in the current fiscal year. While these amounts are not alarming, they are sufficiently high to make the government look very carefully at any further commitments. This, I would suggest, is a factor in our attitude towards the capital side of hospital insurance. But—and I want to emphasize this — it is far from being the governing one.

(concluded on page 88)

Progress Report
(concluded from page 86)

Of greater significance is the question of maintaining the autonomy and independence of Canadian hospitals. Our whole tradition of health care is based on this autonomy and we are anxious—as I am sure you are—that nothing be done to weaken or undermine it. I am not saying that the inclusion of capital costs within the insurance program would necessarily have this effect. Not at all. My point is this. Because of our lack of experience in the field, we have no way of knowing whether the assumption by government of both operating and capital costs might constitute a first step towards centralized ownership and control of hospitals. This may or may not be the case, but I believe we need more experience with the insurance program before attempting a final decision.

The matter of autonomy is an important consideration but there are practical problems as well. One of the major obstacles is the wide variation in *per capita* hospital debt across the country. The variation is so marked that an equitable solution on a national basis would appear exceedingly difficult. This is the crux of the problem and I have yet to hear of a way out of it.

While capital costs have been excluded from the insurance plan, the Dominion government has maintained its support of Canada's hospital construction program. In fact, even before the insurance plan came into operation we doubled our grants for new hospital beds and extended federal assistance to renovation and improvement. I can assure you there will be no lessening in this support, nor in the importance we attach to the national health grants generally. The latter may have been somewhat overshadowed in recent months by the introduction of the insurance scheme, but in the eyes of my department they still represent one of our key health endeavours.

At the same time, it has been necessary to re-examine the grants system in the light of the insurance scheme. This reappraisal — which I might add has not been of the "agonizing" variety — is still not completed. Already, however, cases of likely duplication of federal support have been eliminated. Studies have also been initiated as to how funds so released might be reallocated towards filling certain gaps in our health services.

On behalf of my department, may I say, that we appreciate the fine spirit of co-operation which this association has extended in our many areas of mutual interest. With the continued development of a program of supreme importance to us both, we look forward to even closer ties in our common effort to further the cause of health progress. ■

ACHA to Meet at the Met

The Metropolitan Opera House and the Waldorf-Astoria Hotel in New York City are the sites for both the annual Convocation and the banquet of the American College of Hospital Administrators this year. The president, Anthony W. Eckert, pointed out that the Met would soon be razed and the College event is among the last of the activities to be presented there. The date is August 23, 1959.

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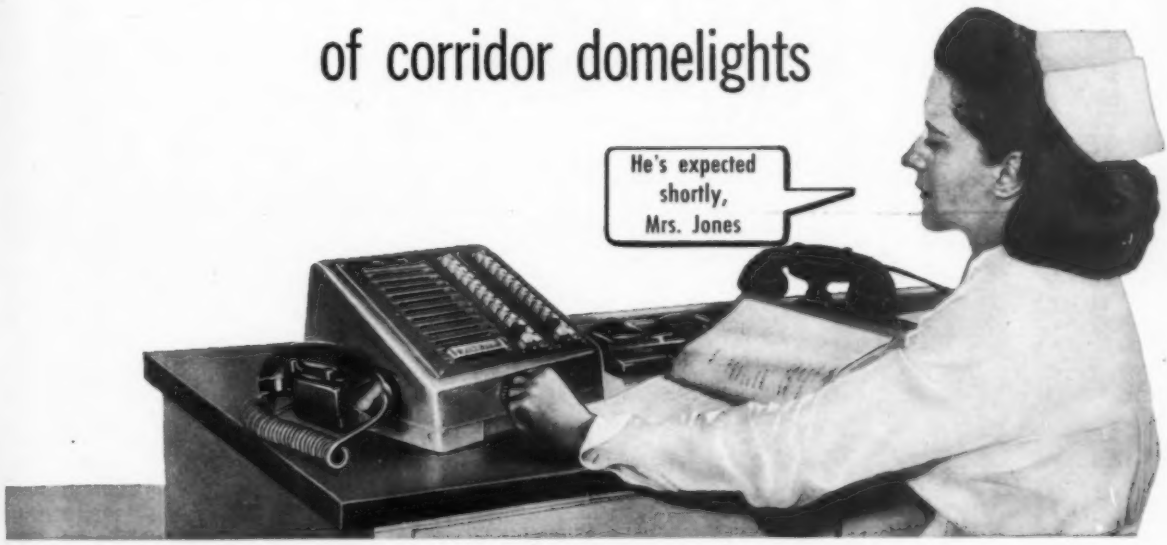

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Double Harness

(concluded from page 44)

most people want to stay in hospital. However, the experience of insurance plans indicates that the length of stay increases. I suspect that it is the chronically ill patient who is responsible for this increase. Active treatment stay could well be decreasing. Time will supply us with some of these answers.

The Community

The final team I want to talk about is that of the hospital and the people. You are well aware that the provision of capital for the building of hospitals is a shared responsibility. At the present time, in Ontario at least, only about one-third of the cost of an active treatment hospital bed is provided by the two levels of government. This is increased somewhat for chronic and convalescent beds. It is obvious, therefore, that a large amount of the funds necessary to build a hospital must come from the people, both through the direct help of the municipalities and from private philanthropy.

While I am free to admit that I would like to see a somewhat larger contribution from the two levels of government, I would not want to remove from the community the opportunity to participate in hospital development. To do so would convert our hospitals into state institutions. The very nature of the service hospitals render to people commands the interest and the support of the community which it serves. The public conscience of the community can be judged by its hospitals. I am disturbed that so many of our municipalities are attempting to evade this responsibility.

There is no question that we need more hospitals of all types. We need also more homes for our elder citizens. These should not be using badly needed hospital beds. Only by the fullest co-operation of all those concerned can these problems be solved within the ability of the economy of the country.

Team work is necessary. I have mentioned the composition of only a few teams. They may be harnessed in many ways; but however they are harnessed it is important that, when they pull, they pull together and in the same direction. ■

Not many sounds in life exceed in interest a knock at the door.

A New Era

(concluded from page 56)

great deal of the board's and the administrator's time. Freedom from this obligation should leave time and energies to concentrate on the more positive aspects of our service, and for the telling of our story to our own local council and those of our neighbouring municipalities in a much more constructive fashion. Undoubtedly our relations with certain of our local, elected councils have always been coloured by overtones of what we considered to be financial injustice. If the situation develops as we believe it will, we should immediately take steps to establish relationships with these groups on a more amicable basis.

The assistance provided to many hospitals by their well organized and active women's auxiliaries also takes on greater significance.

Services and supplies provided as donations by these groups and others are a clear cut gain for the hospital. Routine supplies, such as linens, customarily provided by the auxiliary, may be valued and recovered as an operating expense in the shareable part of the budget. Perhaps much more important is the opportunity presented through the introduction of the plan for a fresh evaluation of how best the auxiliary can continue to assist the hospital. These women through their various projects do a great deal to identify the hospital with the community, and as a group well informed on the current operations of the hospital they can assist in interpreting the hospital as a continuing responsibility of the local community. We should do everything we can to encourage them in their work and be sure to explain clearly how much they are needed.

A new course has been charted. We are all affected by what we must believe to be new opportunities for increased service. It would seem apparent that if we can continue to keep the citizens of our communities in full sympathy with the aims and objectives of our local hospitals, we shall continue to progress. We will never accomplish this objective by hiding our light under the proverbial bushel. And finally, I believe hospital people will have to take a fresh look at how this may be accomplished—a fresh look in the sense it derives not from the sentiments and practices of the past, but from the realities of what is happening now. ■

Food Preservation

(continued from page 68)

the products made from the treated flour. Irradiation doses of 150,000 rep were found effective in curbing brown rot in peaches with no noticeable changes in flavour. The life cycle of trichinae in pork was interfered with when the meat was subjected to doses of 12,000 rep thus preventing the growth of trichinae in pork.

Conclusion

Much research and experimentation must still be carried out before irradiated foods will be available on the market. Methods have to be perfected for eliminating many of the flavour, colour and texture changes which are now evident in some of the foods. More precise dose measurements must be determined for the foods, along with safety precautions to ensure

(concluded on page 94)

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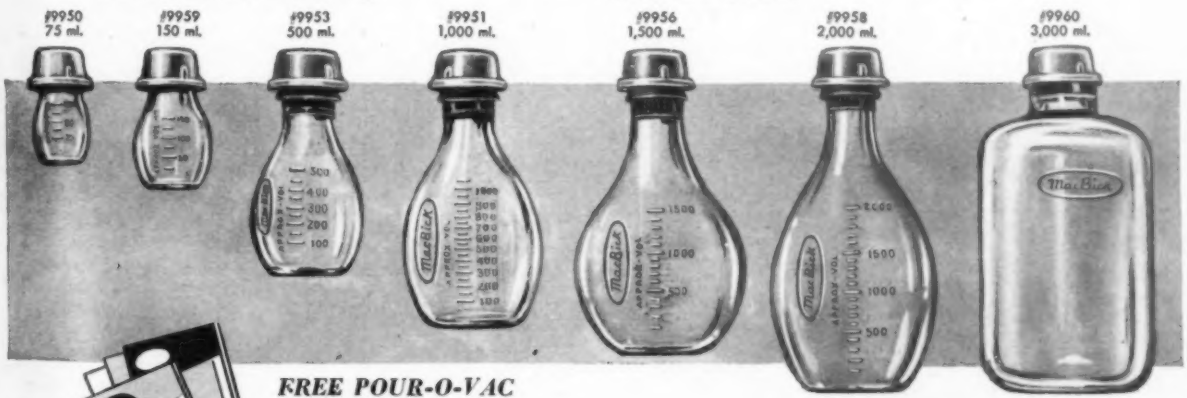

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Food Preservation

(concluded from page 92)

the adequate sterilization of the products. New techniques and styles of packaging must be considered to give the required protection. Human feeding experiments are being carried out and many more must be concluded before the food can be considered safe for general consumption. The public will undoubtedly have to be educated to accept these foods which may have slightly different quality characteristics than the foods which they now consume.

These are just a few of the problems which must be solved before commercial cold sterilization can become an accepted process for food preservation.

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Saskatchewan Cuts Health Services

The government of Saskatchewan has been forced to cut its health services to recipients of such government aid as old age pensions and mothers' allowances. Previously, these people received free drugs and free visits from physicians when hospitalized. Now the government will pay only 50 per cent of the cost of drugs and will pay for hospital visits by physicians only during the first 15 days of hospitalization.

The reason for this move is the sharp rise in the use of drugs and the abuse of the free visits from physicians.

Exceptions to the new ruling will be made in urgent cases if these are brought to the government's attention. Insulin for diabetics and essential drugs for persons suffering from pernicious anaemia will remain on the free list.

What's Gnu?

A lion and a lioness seeking their supper came across half a dozen gnus. With six blows of his powerful paws the lion killed the lot.

"That", he said, turning to his mate, "is the end of the gnus. The time is exactly twenty-two minutes past nine."

You and Your Association
(continued from page 45)

the community is working for each one who is part of it. But the reverse is not true and the fact that a few can find their profit does not mean that the community has gained something. People who do not conform with this rule are only parasites.

A common activity creates unity among members. They become, in this respect, like the members of a family or the citizens of a country. If you happen, for example, to travel in a foreign country and, by accident meet a fellow citizen, so far unknown to you, he and you almost immediately will become good friends and try to help each other. If you only hear that one of your fellow citizens lives some where around, you will go and find him. Similarly, the members of an association must have the same feelings towards their fellow members; that is, a sense of solidarity and mutual regard.

Let us go on with this comparison between the citizens of a country and the members of an association. I would like to underline the fact that, in the great majority of cases, a country does not choose its citizens. Although our government is not obliged to accept the hundreds and thousands of immigrants who may seek their entrance into Canada, it has to keep those millions of men and women born Canadian. Endowed with the rights of a Canadian citizen from the very first day of his life, a Canadian by birth does not always realize the great advantage of belonging to such a country as ours. It is only by comparing his life with that of other men living in countries less favoured that any Canadian comes to realize his good fortune. But all Canadians do not make such comparisons. Speaking of an association, we seldom join it when we come into this world. There are associations that everyone can join but one is not particularly proud of belonging to them. On the other hand, there are others where members are carefully selected. In a group like yours, a first barrier is erected by restricting membership to a category of persons of the same profession. But, more than that, your executive committee is not bound, under your bylaws, to accept as a member of your association such or such a person in particular although she is a med-

ical record librarian. Consequently each one of you has twice deserved her membership in the association and you should be proud of it.

One thing remains: once you have been admitted into the association, you are entitled to the constitutional privileges of the members (such as notices, right of vote, right of offices) and to institutional advantages (such as information, prints, conventions) in the same way as a citizen is entitled to vote at elections and to receive old age pension when he reaches seventy years of age.

Let us come now to the duties and responsibilities of the members of a association. Quite a few people consider that they are not indebted towards the society to which they belong because they hardly avail themselves of its services. We must admit of course that the zeal of members usually corresponds to the advantages they get from the association. This is nothing to be disturbed about. A person is a better member if he draws as much advantage as he can from his association yet does not begrudge his efforts and time. Our civilization finds its meaning under the symbol of interest and we must take it the way it is. There is nothing good to say about disinterestedness when it means indifference or inertia.

Your main duty will be, therefore, to interest yourself in your association, know its charter, its bylaws, its history, the names of its officers, its size of membership, its function and various services. This also means take advantage of your association. By making use of the activities and services at your disposal, you justify the association's existence. You cannot testify in its favour in a better way than to put your trust in it. In a family, parents are only too happy to see their children eat with appetite; in a class, the professor is only too happy to give all his knowledge to his ambitious students; in the same way your officers will only be too pleased to realize that the association is useful to the members. As Canadians, you are entitled to everything Canada offers to its citizens from its legislation to the personal wealth you may draw from your activity, to the natural beauties you may see if you travel across the country, and to the institutions if you happen to need

(continued on page 98)

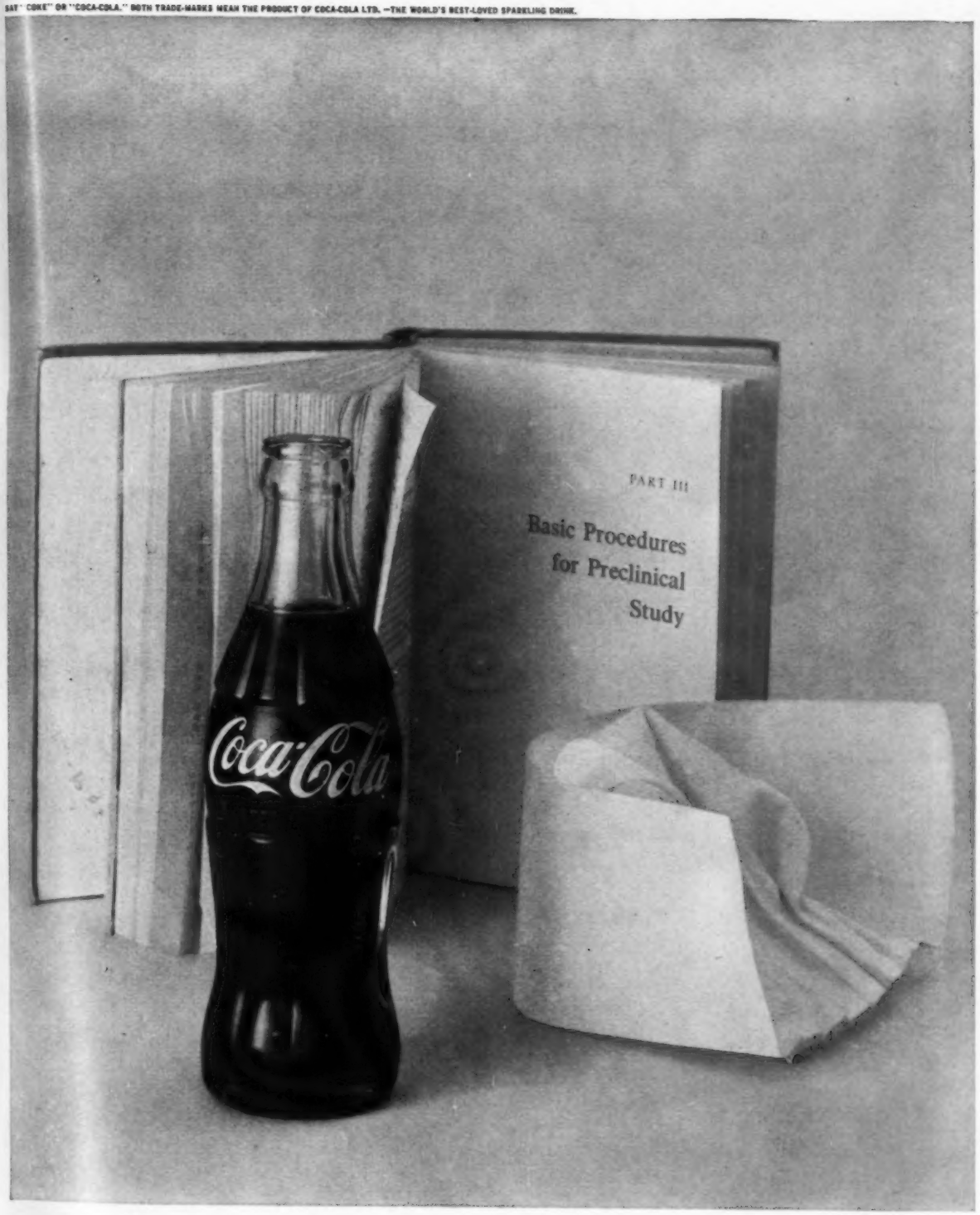
You and Your Association
(continued from page 97)

them. And I do not think that any of us will be ashamed or will feel shy because he tries to have as good a life as he can in Canada. Do not hesitate to do the same—have in your association and by your association a useful life, a satisfying life, without being unfaithful to the fundamental idea of service to the collective whole.

Let us now consider the relationship between the members and the officers of an association. We may take as a model the duty of allegiance that binds the citizens of a country towards the state. This duty has a military origin. We know from history that the Roman soldier had to take an oath of allegiance, symbol of his loyalty to his commanding officer. Even nowadays, various persons must take the oath of allegiance. Everyone is bound by the duty of allegiance although he does not have to take the actual oath. The violation of this duty is the greatest of crimes, that of treason. I do not mean that, if you betray your association in some way or other, you commit the crime of high treason. I simply want to stress the point that the officers of an association have a claim to the loyalty of the members. Ill-will, criticism, indifference, ungratefulness are but too frequent. Of course one must not close one's eyes and give up all personal opinion. On the other hand one must appraise the value of a personality, be grateful for faithful services, praise the accomplishments. Men are remarkably gifted for finding out the weak spots and in denouncing mistakes and omissions, but remarkably poor in appreciating and giving thanks. Let us show good will and co-operation with the officers of our associations.

A citizen also has the duty of accepting unpaid offices. You find the same obligation in every association. A good member must not run away from responsibilities. There are people who always find excuses to let the others do the job. They don't realize how unjust they are towards the association and their fellow members. Although they witness the president's responsibilities and activities, the secretary's work and so on, they are only relieved when the officers holding these functions are re-elected year after year. Keeping the same persons

(concluded on page 100)



When too many tasks seem to crowd the unyielding hours,
a welcome "pause that refreshes" with ice-cold Coca-Cola
often puts things into manageable order.

You and Your Association
(concluded from page 98)

in office may be good, but this is not always the case. The important thing is to select officers not for egotistic motives but for the well-being of the association. And when it is your turn to assume some responsibility, it will be your duty to say "yes", duly loyal towards your association, duly grateful towards your predecessors. ■

Your President Reports
(continued from page 42)

our hospitals both at the national and international levels. You alone are competent to judge whether my visits with you assisted in this objective or whether they acted as a deterrent. I do suggest to you that the only hope for survival of the voluntary hospital as we have known it up to now is in and by unity. This I have fervently strived for during my two years as your president.

In spite of the important function of our national association in its liaison with the federal government, I still feel that our primary function continues to remain in the field of education, using that term in its broadest sense. Others will report on this work in greater detail, giving you a resumé of what has been accomplished and what is being planned for the future. Suffice it to say just now that probably 90 per cent of the time of our total staff at headquarters is devoted to education over a very broad field and we have gained international recognition of some of our projects. We hope that the assistance given by executive staff and officers at institutes and conventions has been practical.

In my opinion, an officer of our association must be prepared to devote most of his *personal* time, and a considerable portion of his time as an employee or an associate, to the duties of his office if our national association is to continue to progress under its present constitution. Although I have already done so under more private circumstances, I would wish now to thank publicly the governing council and the individual administrators of the hospitals to which I act as consultant for the encouragement and understanding which has permitted me to be absent from my regular activities to carry out the various duties of president of your association. A similar word of thanks to my partners in our consulting firm—they have always

taken the attitude that they wished me to take whatever time I felt was required to perform adequately my responsibilities as president.

My fellow officers and directors have been diligent in their duties and responsibilities. They have been tolerant of my idiosyncrasies, and have been indulgent when I acted as chairman of their meetings. The honorary vice-president, Dr. J. Gilbert Turner, gave me generously of his time and experience—my grateful thanks for these and for his willingness to act as leader of the last delegation to Ottawa, when I was unavoidably absent.

The very great and real difficulty which was experienced in getting together a proper quorum of important committees at necessary times leads me to recommend to the incoming board of directors that more responsibilities be placed on the shoulders of our executive staff in the interest of overall efficiency. This suggestion in no way is intended to detract from the important work carried out particularly by the education committee, the committee on accounting and statistics, and the building committee.

By constitution and by custom we are vulnerable regarding appointments to our board of directors. No yardstick has been provided for regional representation, no provision has been made to provide for orderly retirement on a rotation basis, and (in my opinion at least) the custom of using a nominating committee is both undemocratic and obsolete.

This assembly should be acutely aware of the very high-calibre staff we have at headquarters. They work under the handicap of a very inadequate physical plant, plus an ever-increasing load of important detail without enough people. I would like to live long enough to see the day when Dr. Piercey would not have to worry about innumerable details which could well be passed on to others. My association with him in the past two years has been a rich experience for me — he is tolerant, patient, co-operative, and highly competent. To Dr. Piercey, therefore, my thanks and gratitude.

To many across Canada, Murray Ross has come to be known as "Mr. Hospital". To Mr. Ross my real thanks for not vacating his appointment* before I completed my term as president.

*See Canadian Hospital, March, 1959, page 10.

(concluded on page 102)

Your President Reports
(concluded from page 101)

One cannot complete a term as president of an association such as ours without a feeling of inadequacy, coupled with a feeling of very real gratitude and justifiable pride. One cannot complete such a term of office without having had ingrained a sense of loyalty which nothing can shake. I have such gratitude—I have such pride—I have such loyalty. ■

What's the Difference?
(continued from page 40)

and the sporting world are regular visitors to the children's hospitals.

Dietary

Those interested in analyzing hospital costs will immediately be struck by the difference in the food service budget of a children's hospital from that of an adult hospital. Menus are simpler and portions are smaller. There is no selective menu. Approximately 25 per cent of the patients do not have regular meals but are bottle fed. An examination of cost figures indicates that it costs about one-third as much to feed this type of patient as it does to feed children who have meals. Approximately 750,000 bottles of milk and formula are prepared annually in The Hospital for Sick Children's "Dairy".

Laundry

Laundry and clothing are major problems in a children's hospital. The clothing which the child is wearing at the time of admission is sent home with the parent. The child is given clothing to wear in bed and also clothing to wear when he is an up-patient. Thus one additional sub-department of laundry and linen control is the "Up-Patient Clothing Department". Children are also given a toothbrush and comb on admission.

Generally speaking, more laundry is required per patient per day in children's hospitals than in adult hospitals, and the amount is rising! It is estimated that the laundries of the 12 Canadian children's hospitals wash more than 5,000,000 diapers per year. Other items which appear on the laundry lists of children's hospitals are bibs, bunny blankets, panties, jockey shorts, white stockings and white socks.

Patient accommodation

Visitors are often struck by the absence of four things normally found in adult hospitals—namely, nurses' call bells, telephones, closed doors to patients' rooms and private

accommodation. During 1957, for example, the Children's Hospital of Halifax admitted only one child as a private patient. During 1957, only .41 per cent of the admissions to The Hospital for Sick Children were private. It is a generally accepted fact that children convalesce much more satisfactorily in a room with another child or with other children.

Orthopaedic shop

One of the special services sometimes found in children's hospitals is an orthopaedic shop. The price list of the orthopaedic shop of The Hospital For Sick Children contains 94 different items. Over 5,000 appliances are produced annually.

Poison control centre

Poison control centres are found in many adult hospitals. However, they are becoming more and more a regular feature of children's hospitals. Some are financed by federal and provincial government research grants, some by local departments of health, and some by the hospitals themselves. Thousands of frantic telephone calls are received annually from distressed parents, and hundreds of children who have ingested poison are rushed to hospital. In Figure 3 are some figures taken from the records of the poison control centre of The Hospital for Sick Children for the 12 months ended April 30, 1958. Headache tablets (acetylsalicylic acid) accounted for 277 cases (32 per cent of the total). Children two years old accounted for 40 per cent of the above total number of cases treated.

Community support

Children's hospitals have a strong appeal to the community. Women's auxiliaries, the Junior League, and other organized groups as well as individual donors provide a great many services within the hospital. Financial support in the form of legacies and gifts is provided by citizens of the community, many of them in grateful memory of a child who has been successfully treated, and some in memory of a child who has been lost.

There *is* a difference in children's hospitals. The patient is different, the treatment is different, the food is different and the hospital itself is different. ■

Red Cross

It is estimated that 97 per cent of the work of the Canadian Red Cross is done by volunteers.

The Canadian Red Cross Society will celebrate its 50th anniversary in 1959.

Classified Advertising

Pathologist Required

280 beds, general hospital with active clinical pathological laboratory. Expansion planned, including large laboratories. Accredited hospital with approvals for junior internes' residents in general practice. Registered laboratory technicians. Write or wire Administrator, General Hospital, Port Arthur, Ontario.

X-Ray Technician

For 250-bed hospital, completely new, in Eastern Ontario. Experienced Radiological Technician, preferably male. Apply in writing for further details to Box 607H, Canadian Hospital, 57 Bloor Street West, Toronto.

Superintendent Wanted

Applicants are requested for the position of Lady Superintendent and Administrator of The Rosamond Memorial Hospital, Almonte, Ontario. The institution is a small well equipped general hospital in a community of three thousand people and serves a fairly large rural area—situated close to Ottawa, there is good rail and road communication with the Capital and other communities in the Ottawa valley. Applicants are requested to provide references with a resume of past experience and salary expected. Apply: Secretary-Treasurer, The Rosamond Memorial Hospital, Almonte, Ontario.

Administrative Position Wanted

Recent graduate of H.O.M. Course seeks position as Administrator or Business Manager. Extensive experience in Business Administration and Hospital Finance. Presently employed, medium-sized hospital. Complete information on request to Box 618W, Canadian Hospital, 57 Bloor Street West, Toronto.

Pharmacist Required

by Orillia Soldiers' Memorial Hospital, Orillia, Ontario. Applicant will be required to set up Department. Apply: Wm. A. Hume, Superintendent.

Director of Nursing Required

for 88 bed hospital located in busy town of 4,000 people. Well equipped hospital offering a challenging future. Salary offered and qualifications desired are in accordance with suggested R.N.A.O. schedules. Apply—Administrator, Lady Minto Hospital, Cochrane, Ontario.

Wanted General Duty Nurses

for 88 bed hospital in a town of 4,000 in Northern Ontario. Salary according to Ontario Registered Nurses Association recommended schedule. Apply in writing to — Administrator, Lady Minto Hospital, Cochrane, Ontario.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

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ASSISTANT PROFESSORSHIP in HOSPITAL ADMINISTRATION

University of Toronto
School of Hygiene

Vacancy in department of hospital administration. Must be university graduate and preferably hold diploma or degree in hospital administration. Duties to include teaching of hospital administration and related subjects. Salary according to university schedule. Position vacant July 1, 1959. Applications and enquiries to:

Dr. A. J. Rhodes,
Director, School of Hygiene,
University of Toronto,
Toronto 5, Ontario.

HOSPITAL ADMINISTRATOR
for
JOSEPH BRANT MEMORIAL HOSPITAL
BURLINGTON, ONTARIO

New 170 bed hospital on lakeshore site to be ready for fall of 1960.

Apply in writing, giving full particulars as to age, marital status, education, experience, present salary and references to:

Mr. A. S. Nicholson, Chairman, Board of Governors,
c/o F. J. Horsley, Secretary,
1240 North Shore Blvd.,
Burlington, Ontario.

UNIVERSITY OF ALBERTA HOSPITAL
invites applications for position
of
DIRECTOR OF DIETETICS

Duties: Direction of training of Dietetic Interns, Diet Therapy, Meal Planning, and Nutrition generally. (Food distribution, mechanics and catering are responsibility of a Food Administrator.) Excellent security contract. Please give full details regarding curriculum vitae, experience, and salary required in first letter addressed to.

Personnel Officer.

ASSISTANT DIETITIAN REQUIRED

Please apply stating
Experience and Qualifications
to

The Superintendent,
Peterborough Civic Hospital
Peterborough, Ontario

Dietitian Wanted

for modern 65 bed general hospital 20 miles north of Winnipeg, Manitoba. Excellent working conditions, annual leave etc., salary open to negotiation. Apply to F. D. Butler, Administrator, Selkirk General Hospital, Selkirk, Manitoba.

The new
BRANTFORD GENERAL HOSPITAL
of 500 beds

is inviting applications for the position of Assistant Administrator. Applicants must have background in hospital administration, and also be able to assume responsibility, and direct in-service training program.

Applicants should state qualifications, experience, age salary expected, and other particulars as to availability for interview.

All applications will be treated in strict confidence, and should be addressed to:

The Administrator
BRANTFORD GENERAL HOSPITAL
Brantford, Ontario.

STATISTICIAN FOR HOSPITAL STUDIES

Required by

Department of National Health and Welfare

Ottawa

$6,360-$7,320

The statistician selected will be responsible for the development of an efficient system for the processing of annual hospital returns covering service, patient movement, and financial data.

Candidates must be university graduates with specialization in statistics or in a related field, and have a number of years of experience in statistical analyses.

For details, write to

CIVIL SERVICE COMMISSION, OTTAWA

Please ask for Circular 59-2303A

QUALIFIED DIETITIAN

Required to assist Chief Dietitian in a 350 bed general hospital located in South-Western Ontario.

Salary $3,840.00-$4,200.00 per annum.

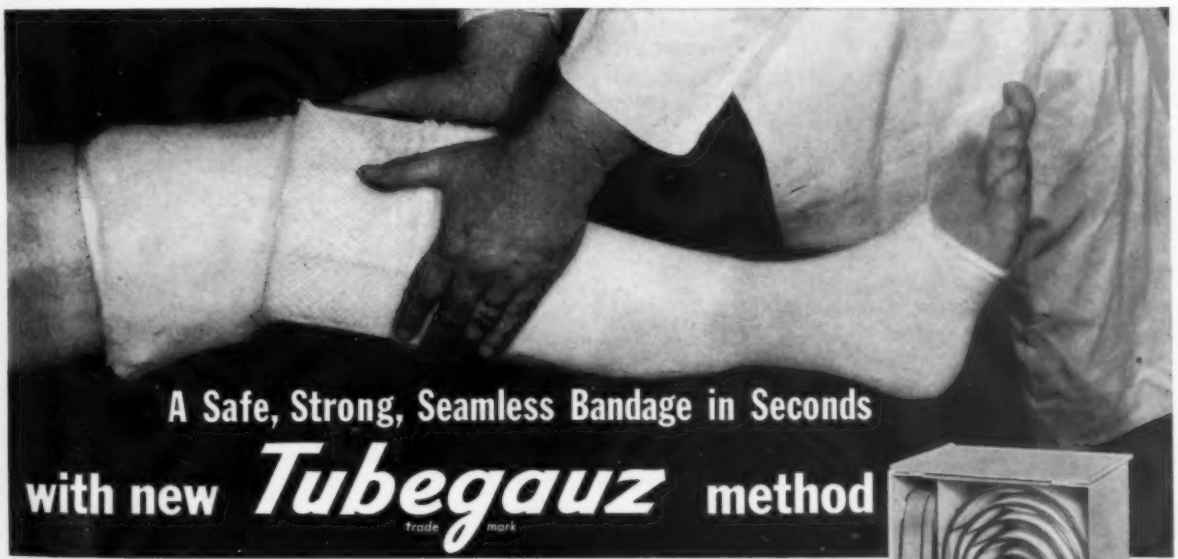
Excellent personnel policies including 40 hour, 5 day week, and generous employee benefits.

Apply to:

Personnel Department,

Metropolitan General Hospital

Windsor, Ontario.



Only tubular bandage method using special applicators

Tubegauz can be applied in fraction of usual time. Gives firm, complete and comfortable covering. Strong yet soft . . . stays in place. Can be washed, sterilized in the autoclave and used **many times** without loss of its special characteristics. Made from double-bleached highest quality cotton yarn. Woven in seamless tubular rolls. Molds to exact shape of limb. Applied with patented applicators which make it unusually adaptable and efficient in dressing hard-to-bandage areas.

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Only Tubegauz won't ravel or fray . . . Accept no substitute.

Order Tubegauz from your Surgical Supply House, or from:

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LIMITED
174 BARTLEY DRIVE, TORONTO 16
World's Largest Maker of Foot Aids

News Released by Hospital Supply Houses

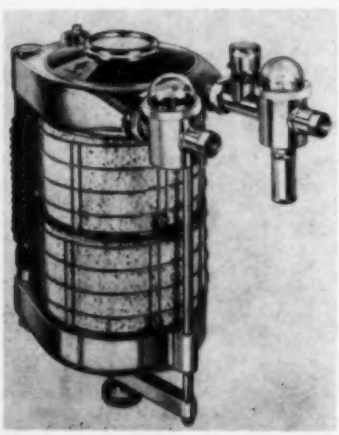
By C.A.E.

New Features in Canister Absorber and Valve

The Ohio Chemical Canada Limited, 180 Duke Street, Toronto, (Division of Air Reduction Company, Inc.), announces the availability of new twin plastic canister absorbers and the new Swivel "Y" inhaler valve.

Twin, interchangeable transparent canisters are featured in the new Ohio Models 20 and 21 absorbers. The canisters are made of tough, break-resistant plastic. Each incorporates its own screen, and each canister will hold approximately three pounds of soda lime.

The direction of flow is normally from the top to the bottom in the absorber. Therefore, the top canister of soda lime is exhausted first. When the colour change is complete in the top canister, both canisters are removed. This is a simple operation in that the bottom section of the absorber is lowered by merely turning a knurled knob at the bottom of the absorber. The top exhausted canister is refilled and replaced on the bottom. The partially used bottom canister is now placed in the top position. In this way all of the soda lime in each canister is effectively used.



The swivel "Y" valve permits the anaesthesiologist to switch easily from mask to catheter without changing fittings. The exhalation and inhalation valves are an integral part of the Swivel "Y" Valve and direction of gas flow is clearly marked on the valve. The "arms" swivel freely in a 360° arc to simplify adaptability to catheter or mask.

For complete information on these two new Ohio products please write directly to the company and request catalogue section No. 2418.

Picker Publishes Planning Book for Medical Center Architects

A new loose-leaf "X-Ray Department Planning Book" covering installations for every phase of x-ray and radioisotope applications has been published by Picker X-Ray Corporation for hospital and medical center consultants and architects.

The company said the first three sections, on the planning of one-, two-, and four-room diagnostic x-ray suites, are now being distributed. These and the following sections are available on request. Each section includes layouts, wiring diagrams, electrical specifications and construction details.

Following sections, the company said, will be:

Section IV—O.R. suite.

Section V — Special diagnostic procedures x-ray rooms, chest admission and emergency room.

Section VI—Darkrooms.

Section VII—Viewing areas and offices.

Section VIII—Therapy suite.

Section IX—Radioisotope suite.

Section X—Electrical codes and general information.

Included with the book is an equipment template for laying out scaled plans. For complete details, write to: Picker X-Ray Engineering Limited, 1074 Laurier Avenue West, Montreal, Quebec.

"Tissuemat" Formulation For Preparing Specimens

Tissuemat, special formulation of Fisher Scientific, for infiltrating and embedding specimens for microscopy, now offers individual lot analyses guaranteeing the melting point.

The melting point of each lot is determined according to the official method of the American Society for Testing Materials and is printed on a certificate enclosed with each package in that lot.

In all, some 32 tests are now performed on Tissuemat, including rigid clinical tests (microtoming, staining, et cetera) as well as chemical ones.

Result: in addition to guaranteed melting point, Fisher Certified Tissuemat assures strict colour stability, optimum viscosity, excellent microtome ribboning, min-

imal microtome compressibility, maximal elasticity, complete solubility in xylene, no staining interference, and no internal cracking.

Write to Fisher Scientific Limited, 8505 Devonshire Road, Montreal 9, Quebec.

A. S. Aloe and Brunswick Plan to Merge

Plans to merge the A. S. Aloe

(continued on page 108)

Across the Desk

(continued from page 106)

Company of St. Louis and the Brunswick-Balke-Collender Company of Chicago have been announced by Howard F. Baer, president of Aloe.

Aloe, a 99-year old firm is both a manufacturer and distributor of some 30,000 items to hospitals, physicians, and clinical, technical, and industrial laboratories in the United States, Canada and abroad. The company will continue to operate as a separate institution, Mr. Baer said. The same policies, executives, employees, plants, the same sales, manufacturing and office staffs will continue to operate Aloe. No changes in manufacturing, sales, or distribution policies will be made because of this merger, he stated.

Aloe headquarters will remain in St. Louis, and all other of its sixteen divisions and warehouses in all parts of the country will remain unchanged.

"The great resources of the combined companies will make it possible for us to expand inventories and facilities to serve our Aloe customers even better—and in this way provide more job opportunities and greater security for all employees," Mr. Baer said.

Hot/Cold Water and Refrigerator in New Cordley Bubbler

A new bubbler type electric water dispenser that serves hot and cold water and provides refrigeration for foods and beverages has been introduced by Cordley & Hayes.

Called the HCH-5, the new unit will deliver 60 six-ounce cups of 190 degree (F) water per hour for instant hot beverages; enough 50 degree (F) cool drinking water for 60 or more persons per hour; and store at refrigerator temperatures a generous supply of bottled beverages and other food in a roomy one-cubic-foot compartment that also freezes two large trays of ice cubes. The compartment can be locked to insure privacy.

The cooler's fully sealed refrigerant system, 1/5 h.p. motor-compressor and fan cooled condenser are enclosed in an attractive infra-red baked grey steel cabinet that has a recessed base and stainless steel top.

According to a company spokesman, the new HCH-5 is covered by the same unique five-year guaranty available on all coolers in the Cordley line.

For additional information about the HCH-5 write: Cordley & Hayes, 443 Fourth Avenue, New York 10, New York.

Adams Compact Centrifuge Now Available

The new Adams Physicians Compact Centrifuge, manufactured by Clay-Adams, Inc., New York 10, N.Y., is specially designed to handle all routine sedimentation tests carried out in the doctor's office laboratory.

It is compact, light and sturdy, with a speed of 3400 RPM. This comparatively high speed, combined with the angle principle—tubes are held at a 45° angle during centrifugation—provides fast and efficient separation and deposition.

It is equipped with a precision-machined 4-place aluminum head, balanced to assure smooth operation, and removable aluminum shields accommodating 15 ml. tubes.

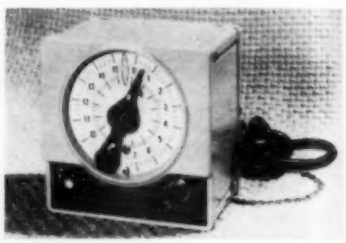
Maintenance problems are minimized by a brushless motor with self-lubricating sleeve-type bearings which require no lubrication for 2000 hours, or about 2 years normal use. The motor is ventilated to prevent overheating. It operates on 115 volts, 60 cycles, AC.

Additional details may be obtained from the manufacturer, Clay-Adams, Inc., 141 East 25 Street, New York 10, New York.

Westinghouse Electric Darkroom Timer

A new Westinghouse electric timer for X-ray photographic processing is now available from X-Ray & Radium Industries Limited, 261 Davenport Road, Toronto.

The device embodies automatic time resetting. Only a single setting of the two indicators to the required time period from one to 15 minutes is needed.



By flipping the switch to the "on" position, the timer repeats the setting accurately until a change is made on the larger indicator to another setting. When the switch is in the "off" position, the red indicator returns to the established setting, automatically resetting to time the same interval. Therefore, uniform timing in processing is now possible.

Other advantages of the new timer include the elimination of repetitive motion in the busy darkroom, and the elimination of possible error due to slippery fingers of the time settings.

Finished in ivory enamel with a green nameplate, the timer is moderately priced and carries Underwriters Laboratories listing.

Automatic Laminator Preserves Records

Lifetime protection for valuable papers, drawings, photographs, and hundreds of other items is provided by the GBC Automatic Laminator announced by General Binding Corporation, Toronto. Designed for institutional use, the Laminator encases paper, card, board, or cover stock in clear, tough film in only 3 seconds time.

Material sealed in this thin

(concluded on page 110)

NO "FAT PROBLEM" with MIL-KO

—No Flavour Problem Either!

Ever since new flavour Instant Mil-ko began fooling confirmed "whole milk" drinkers of all ages in blindfold tests, Doctors have been recommending it to fat problem cases. And not only does Mil-ko offer a fresh sweet pasteurized flavour, not only does it have all the undesirable fats removed . . . but it also saves patients money because expensive water is also removed. Mil-ko saves up to 16c a quart! Perhaps you, too, would like to have Mil-ko in **your** home, Doctor.

CHATELAINE INSTITUTE SEAL OF APPROVAL

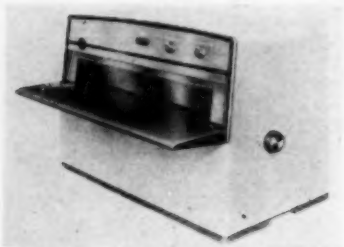
MIL-KO PRODUCTS LTD.
HAMILTON, ONTARIO

MI-1537

Across the Desk

(concluded from page 108)

pliable plastic shield is tamper-proof, impervious to dirt, grease and acids, stainproof, and immune to wear and tear. The film is completely stable, and laminated material always lies flat.



According to the manufacturer, the Laminator can be operated by anyone without special training.

Although occupying no more space than a typewriter, the unit applies over 200 pounds of pressure to assure perfect lamination, even on rough or torn surfaces.

The GBC Automatic Laminator will handle material 17 inches in width by any length up to the 2000 foot film roll capacity of the machine. Equal distribution of heat during the lamination process is assured by three automatic thermostats.

For additional information on the GBC Automatic Laminator, write GBC Sales & Service Limited, 355 King Street West, Toronto 2B.

New Floor Wax Resists Scuff Marks

A new improved safety surface wax which has greater resistance to scuff marks, has been introduced by Dustbane Associated Companies.

The new wax has overcome one of the basic problems experienced in the manufacture of safety surface waxes (waxes containing colloidal silica, such as Ludex). In order to provide a satisfactory safety surface, it has been necessary in the past to sacrifice appearance to scuff marks.

Dustbane researchers have been able to produce a finish that provides the necessary safety features and at the same time gives a product that resists scuff marks to a greater extent than ever before. Those marks that do appear retain a high gloss quality that does not detract from the appearance of the floor.

Scuff marks are readily removed with a polishing machine, stiff broom, or mop. An added feature is the wax's ability to be patched in badly worn areas without showing overlap.

Dustbane's new improved safety surface wax is classified by Underwriters Laboratories, Inc., as to slip-resistance. The more applications the greater the slip-resistance.

For further information write to Dustbane Products Limited, 88 Metcalfe Street, Ottawa, Ontario.

Roxalin Introduces New Multi-Colour Finish

Roxalin of Canada announces the introduction of a new version of its famous multi-colour finish, Roxatone.

The new product, to be known as "Premium" Roxatone, is an odour-free material which is easier to use, has equivalent durability to the original Roxatone, and is offered in a new range of subdued colour combinations.

The principal new feature of the Premium Roxatone multi-colour finish is that it has virtually no odour. This is important for redecoration work and speeds up re-occupation of premises, such as hospitals, minimizes inconvenience to occupants and even makes it possible to do inside jobs in cold weather.

There is no problem of "lifting" old paint or varnish. This means that new Premium Roxatone can be used directly over existing paint work, and except where a noticeable change in colour is wanted, one coat does the job. Where the colour change is obvious, a priming coat cuts costs and is indicated.

A newly designed Roxalin vacuum cleaner spray gun is offered which sprays new Premium Roxatone fast enough to spray whole rooms, using present vacuum cleaner. This gun works right off a quart paint can, which is a great convenience.

The new Premium grade is not expected to replace the regular Roxatone multi-colour, but to be complementary to it. Complete details from Roxalin of Canada Limited, New Toronto, Ontario.

Dictating Machine for Doctors

A lightweight, compact, easy-to-operate dictating machine, specially designed to meet medical requirements in the hospital, has been developed by Audograph (Canada) Limited.

Known as the "Caduceus" Key-Noter, the new machine is said to be so small it can almost be carried in a coat pocket, and so light a nurse can easily lift it with her little finger. A full-fidelity, fully transistorized instrument that also doubles as a transcriber, it can be used for recording case histories, prognoses, et cetera, at odd moments during a doctor's day—even while he is making examinations or deciding treatment. The recorded information can then be typed when convenient, either by the doctor himself, by his assistant or by a typing pool.

The "Caduceus" Key-Noter is available in various attractive colours. For complete details, write to Audograph (Canada) Limited, 32 Mendota Road, Toronto 18, Ontario.

Medical Timer

A Swiss watch manufacturer is marketing a new wristwatch for use by doctors in automatically timing a patient's pulse rate. Graduations, viewed through a ring magnifier for accurate reading are set around the outer edge of the dial. A button starts, stops and returns the timer hand to zero position.—*A.M.A. News.*

Twenty Years Ago

From Canadian Hospital, June, 1939.

One of the happiest incidents of the Toronto visit of Their Majesties, King George and Queen Elizabeth, was their voluntary extension of the call at Christie St. Military Hospital. To Christie St. Hospital, one of the few hospitals visited by Their Majesties, come veterans from all over Canada, and the brief stop scheduled by those in charge of the program seemed far from adequate. All Toronto was profoundly touched when the King and Queen, disregarding the schedule, stayed long overtime to chat with these men who had fought so gloriously for King and Empire. It was a gala day and it will long be remembered at the hospital.

* *

At its last session the legislative assembly of Quebec passed an Act respecting the arbitrating of disputes between certain charitable institutions and their employees. This Act places hospital employees in the same class as policemen and firemen and prohibits strikes on the part of these employees.

Any employee going on strike in infringement of the provisions of this Act shall be liable, in addition to the payment of costs, to a fine of not less than ten dollars nor more than fifty dollars for each day's infringement, and failing payment of fine and costs, to imprisonment for not less than eight days nor more than one month. Fines levelled against those persons inciting, encouraging or aiding in any manner an employee to go on strike or to continue a strike in contravention of the provisions of this Act are heavier than for the actual strikers.

* *

A certain intern in a large hospital is having some trouble explaining one of his brilliant diagnoses. An elderly patient, well past the allotted three-score-and ten mark, was diagnosed as having senile dementia, one of the strongest evidences of this state being his insistence that someone "go fetch (his) mamma". Was the intern's face red when a relative did go fetch his mamma—a hale and wiry nonagenerian.

* *

Hospital people, sensitive to the deleterious effect of loud noise, when visiting the World's Fair at New York, should carry ear plugs. Despite the elimination of much of the noise of previous fairs, it is quite impossible to sit in comfort anywhere near the entrance to the amusement portion of the grounds because of the ear-splitting exhortations from amplifiers to visit certain concessions. One of them is still an annoyance at a half mile distance. The out of town visitor is struck, too, by the unnecessary intensity of much of the "canned music" despite publicity given to an elaborate setup for intensity control.

This recalls to mind the comment of the British actor, Sir Cedric Hardwick, who toured this continent last year. He warned us that we as a people are becoming deaf. So many complained about the acoustics of the theatres; they couldn't follow the dialogue. Obviously the explanation was that we are so accustomed to senseless over-amplification at the talkies, to the loudspeaker at luncheons and lectures and to turned-up radios that we have become insensitive to the normal human voice. This is still another reason for getting away to the woods once in a while to listen to the breezes among the pines or to the calls of the unseen birds.